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Health Resources and Services Administration
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Discretionary Grant Performance Measures

OMB No. 0915-0298
Expires: _____

Attachment B
Part 1- Detail Sheets

OMB Clearance Package

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Domain Specific Measures

Program-Specific Measures

Updated DGIS Performance Measures, Numbering by Domain *(All Performance Measures are revised from prior OMB package)*				
Performance Measure	**New/Revised Measure**	**Prior PM Number (if applicable)**	**Topic**	**Estimate of Grantees Reporting**
Women's/ Maternal Health				
WMH 1	New	N/A	Prenatal Care	100
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WMH 3	New	N/A	Well Woman Visit/ Preventive Health Care	
WMH 4	New	N/A	Depression Screening	15
WMH 5	New	N/A	Severe Maternal Mortality/Morbidity	Awaiting Estimate
Perinatal Infant Health				
PIH 1	New	N/A	Safe Sleep	102
PIH 2	New	N/A	Breast Feeding	102
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Child Health				
CH 1	New	N/A	Quality of Well Child Visit	1
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Children and Youth with Special Health Care Needs				
CSHCN 1	New	N/A	Family Engagement	89
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CSHCN 3	New	N/A	Transition to Adult Health Care	84
Adolescent Health				
AH 1	New	N/A	Adolescent Well Visit	10
AH 2	New	N/A	Injury Prevention	3
AH 3	New	N/A	Screening for Major Depressive Disorder	3
Life Course/ Cross Cutting				
LC 1	New	N/A	Adequate Health Insurance Coverage	101
LC 2	New	N/A	Tobacco and eCigarette Cessation	Awaiting Estimate
LC 3	New	N/A	Oral Health	25
Capacity Building				
CB 1	New	N/A	State capacity for advancing the health of MCH populations	251
CB 2	New	N/A	Technical Assistance	215
CB 3	New	N/A	Impact Measurement	392
CB 4	New	N/A	Sustainability	306
CB 5	New	N/A	Scientific Publications	286
CB 6	New	N/A	Products	407
Core				
Core 1	New	N/A	Grant Impact	ALL
Core 2	New	N/A	Quality Improvement	ALL
Core 3	New	N/A	Health Equity – MCH Outcomes	ALL

Program Specific Measures				
Performance Measure	**New/Revised Measure**	**Prior PM Number (if applicable)**	**Topic**	**Estimate of Grantees Reporting**
Division of Workforce Development				
Training 1	New	N/A	MCH Training Program Family Member/Youth/Community Member participation	Program Specific
Training 2	New	N/A	MCH Training Program Cultural Competence	Program Specific
Training 3	New	N/A	Healthy Tomorrows Title V Collaboration	Program Specific
Training 4	New	N/A	MCH Pipeline Program – Work with MCH populations	Program Specific
Training 5	New	N/A	MCH Pipeline Program – Work with underserved or vulnerable populations	Program Specific
Training 6	Revised	08	Demonstrate Field Leadership	Program Specific
Training 7	Revised	09	Diversity of Long-Term Trainees	Program Specific
Training 8	Revised	59	Title V Collaboration	Program Specific
Training 9	Revised	60	Interdisciplinary Practice	Program Specific
Training 10	Unchanged	64	Diverse Adolescent Involvement (LEAH-specific)	Program Specific
Training 11	Revised	83	MCH Pipeline - Graduate Program Enrollment	Program Specific
Training 12	Revised	84	Work with MCH Populations	Program Specific
Training 13	Revised	85	Policy Development, Implementation, and Evaluation	Program Specific
Training 14	Revised	86	Medium-Term Trainees Skill and Knowledge (PPC-Specific)	Program Specific
Division of Child Adolescent, & Family Health- Emergency Medical Services for Children Program				
EMSC 01	New	N/A	NEMSIS Submission	Program Specific
EMSC 02	New	N/A	Pediatric Emergency Care Coordination	Program Specific
EMSC 03	New	N/A	Use of Pediatric-Specific Equipment	Program Specific
EMSC 04	Unchanged	74	Pediatric Medical Emergencies	Program Specific
EMSC 05	Unchanged	75	Pediatric traumatic emergencies	Program Specific

EMSC 06	Unchanged	76	Inter-facility transfer guidelines containing all components	Program Specific
EMSC 07	Unchanged	77	Inter-facility transfer guidelines covering pediatric patients	Program Specific
EMSC 08	Unchanged	79	Established Permanence of EMSC	Program Specific
EMSC 09	Unchanged	80	Established permanence of EMSC by integrating EMSC priorities into statutes/ regulations	Program Specific
Division of Healthy Start and Perinatal Services				
HS 1	New	N/A	Reproductive Life Plan	Program Specific
HS 2	New	N/A	Medical Home	Program Specific
HS 3	New	N/A	Interconception Planning	Program Specific
HS 4	New	N/A	Early Elective Delivery	Program Specific
HS 5	New	N/A	Perinatal Depression Screening	Program Specific
HS 6	New	N/A	Perinatal Depression Follow Up	Program Specific
HS 7	New	N/A	Intimate Partner Violence Screening	Program Specific
HS 8	New	N/A	Father/ Partner Involvement during Pregnancy	Program Specific
HS 9	New	N/A	Father and/or Partner Involvement with child 0-24 Months	Program Specific
HS 10	New	N/A	Daily Reading	Program Specific
HS 11	New	N/A	CAN implementation	Program Specific
HS 12	New	N/A	CAN Participation	Program Specific
Division of Children with Special Health Needs - Family to Family Health Information Center Program				
F2F 1	Revised	70	Provide National Leadership for families with children with special health needs	Program Specific

WHM 1 PERFORMANCE MEASURE **Goal: Prenatal Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/or facilitating timely prenatal care.
GOAL	To ensure supportive programming for prenatal care.
MEASURE	The percent of MCHB funded projects addressing prenatal care.. The percent of pregnant program participants who receive prenatal care beginning in the first trimester.
DEFINITION	**Tier 1**: Are you addressing prenatal care in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you addressing prenatal care? □ Technical Assistance □ Training □ Product Development □ Research/ Peer-reviewed publications □ Outreach/ Information Dissemination/ Education □ Referral/ care coordination □ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # referred **Tier 4**: What are the related outcomes? % of pregnant women who receive prenatal care beginning in the first trimester **Numerator:** Pregnant program participants who began prenatal care in the first trimester of pregnancy. **Denominator**: Program participants who were pregnant in the reporting year.
BENCHMARK DATA SOURCES	Related to MICH Objective #10: Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester (Baseline: 70.8% in 2007, Target: 77.9%)
GRANTEE DATA SOURCES	Title V National Outcome Measure #1, Home Visiting Performance Measure, Healthy People 2020, MICH-10
SIGNIFICANCE	Entry of prenatal care during the first trimester is important to ensuring a healthy pregnancy for both the mother and child. Women who receive delayed prenatal care (entry after the first 12 weeks) are at risk for having undetected complications in pregnancy that can result in undesirable consequences for both mother and baby.

WMH 2 PERFORMANCE MEASURE **Goal: Perinatal/ Postpartum Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating timely postpartum care.
GOAL	To ensure supportive programming for postpartum care.
MEASURE	The percent of MCHB funded projects addressing perinatal and postpartum care. The percent of pregnant women with a postpartum visit within 8 weeks of delivery.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating timely postpartum care in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating perinatal and postpartum care? □ Technical Assistance □ Training □ Product Development □ Research/ Peer-reviewed publications □ Outreach/ Information Dissemination/ Education □ Referral/ care coordination □ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # referred # receiving services **Tier 4**: What are the related outcomes? % of pregnant women with a postpartum visit within 8 weeks of delivery **Numerator:** Pregnant program participants who gave birth during the reporting year and had a postpartum visit within 8 weeks of delivery **Denominator:** Pregnant program participants who gave birth during the reporting year
BENCHMARK DATA SOURCES	Related to Healthy People 2020 MICH- 19: Increase the proportion of women giving birth who attend a postpartum care visit with a health worker.
GRANTEE DATA SOURCES	Pregnancy Risk Assessment Monitoring System
SIGNIFICANCE	Perinatal care is important for mothers to receive to ensure they are getting adequate reproductive health services from trained professionals. Families should be

trained on family planning, pre-conceptual counseling, newborn care, and care for the woman in the postpartum period. Postpartum care is important for the mother and new baby following birth following the many new changes that occur; physically, physiologically, psychologically, and mentally. Postpartum care is targeted to promote maternal well-being and help transition to motherhood along with family planning to include significant others.

WMH 3 PERFORMANCE MEASURE **Goal: Well Woman Visit/ Preventive Health Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating well woman visits/ preventive health care.
GOAL	To ensure supportive programming for well woman visits/ preventive health care.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating well woman visits/ preventive health care and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating well woman visits/ preventive health care in your program? Yes No **Tier 2**: Through what activities are you promoting and/ or facilitating well woman visits/ preventive health care? □ Technical Assistance □ Training □ Product Development □ Research/ Peer-reviewed publications □ Outreach/ Information Dissemination/ Education □ Referral/ care coordination □ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # referred **Tier 4**: What are the related outcomes? % of women with a well woman/ preventative visit in the past year **Numerator:** Adult female program participants who have had a well woman/ preventative visit in the reporting year **Denominator:** Adult female program participants
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Title V National Performance Measure #1
SIGNIFICANCE	A well woman visit is a way to make sure an individual is staying healthy. These include a full checkup, separate from a visit for sickness or injury. The focus is on preventive care which includes, but is not limited to, shots, screenings, education, and counseling.

WMH 4 PERFORMANCE MEASURE **Goal 4: Depression Screening** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating depression screening.
GOAL	To ensure supportive programming for depression screening.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating depression screening and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating depression screening in your program? Yes No **Tier 2**: Through what activities are you promoting and/ or facilitating depression screening? □ Technical Assistance □ Training □ Product development □ Research/ Peer-reviewed publications □ Outreach/ Information Dissemination/ Education □ Screening/ Assessment □ Referred for treatment □ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # screened # referred **Tier 4**: What are the related outcomes? % of women screened for depression using a validated tool **Numerator:** Adult female program participants who have been screened for depression using a validated tool **Denominator:** Adult female program participants
BENCHMARK DATA SOURCES	Related to Healthy People 2020 MICH #34 Objective: (Developmental) Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms.
GRANTEE DATA SOURCES	Home Visiting Performance Measure
SIGNIFICANCE	Fewer than half the cases of postpartum depression are recognized every year. Yet, postpartum depression occurs in nearly 20% of women who have recently given birth. Screening is important not only for the mother, but for children's outcomes as well. Children with depressed mothers are likely to have delayed social and behavioral development.

WMH 5 PERFORMANCE MEASURE	The percent of programs promoting and facilitating assessment and services for severe maternal mortality/ morbidity.
Goal 5: Severe Maternal Mortality/ Morbidity **Level: Grantee** **Domain: Women's/ Maternal Health**	
GOAL	To ensure supportive programming for severe maternal mortality/ morbidity.
MEASURE	The percent of MCHB funded projects promoting and facilitating assessment and services for severe maternal mortality/ morbidity.
DEFINITION	**Tier 1**: Are you promoting and facilitating assessment and services for severe maternal mortality/ morbidity in your program? Yes No **Tier 2**: Through what activities are you addressing severe maternal mortality/ morbidity? ☐ Technical Assistance ☐ Training ☐ Product development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach **Tier 4**: What are the related outcomes? % of providers who are trained in the application of approaches and practices to reduce severe maternal mortality and morbidity **Numerator:** # of providers trained **Denominator:** # of providers targeted through training activities % of women who need and receive services to address severe maternal mortality and morbidity **Numerator:** Number of women assessed to need services to address maternal mortality and morbidity who have received services **Denominator:** Number of women assessed to need services to address maternal mortality and morbidity
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	
SIGNIFICANCE	Severe maternal mortality and morbidity has been increasing in the United States over the past two decades, affecting over 50,000 women per year. Efforts need to be systematically in place to identify and evaluate cases in hopes of reduction.

Source: Kilpatrick SJ, Berg C, Bernstein P, et al. Standardized Severe Maternal Morbidity Review: Rationale and Process. *Obstetrics and gynecology*. 2014;124(2 0 1):361-366.

PIH 1 PERFORMANCE MEASURE **Goal 1: Safe Sleep** **Level: Grantee** **Domain: Perinatal Infant Health**	The percent of programs promoting and/ or facilitating safe sleep.
GOAL	To ensure supportive programming around safe sleep.
MEASURE	The percent of MCHB funded projects addressing safe sleep.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating safe sleep in your program? Yes No **Tier 2**: Through what activities are you promoting and/ or facilitating safe sleep? ☐ Technical Assistance ☐ Training ☐ Product development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Referral/ care coordination ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # referred **Tier 4**: What are the related outcomes? % of infants placed to sleep on their backs in a safe sleep environment **Numerator:** Program participants who report placing infants to sleep on their back in a safe sleep environment. **Denominator:** Infant children of program participants. % of population reporting that a health professional counseled them to put their baby to sleep on their back **Numerator:** Program participants who report a health professional counselled them to place infants to sleep on their back. **Denominator:** Infant children of program participants.
BENCHMARK DATA SOURCES	Related to MICH Objective #20: Increase the proportion of infants placed to sleep on their backs (Baseline: 69.0%, Target: 75.9%), Pregnancy Risk Assessment Monitoring System (PRAMS).
GRANTEE DATA SOURCES	Title V National Performance Measure #5, Home Visiting Performance Measure
SIGNIFICANCE	Sleep-related infant deaths, called Sudden Unexpected Infant Deaths (SUIDS), are the leading cause of infant death after the first month of life. Risk of SUIDS increases when babies are placed on their side or stomach to sleep. Placing babies on their back, on a firm surface, and without loose bedding are the recommended practices to follow according to AAP.

PIH 2 PERFORMANCE MEASURE **Goal 7: Breastfeeding** **Level: Grantee** **Domain: Perinatal Infant Health**	The percent of programs promoting and/ or facilitating breastfeeding.
GOAL	To ensure supportive programming for breastfeeding.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating breastfeeding.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating breastfeeding in your program? Yes No **Tier 2**: Through what activities are you promoting and/ or facilitating breastfeeding? ☐ Technical Assistance ☐ Training ☐ Product development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Referral/ care coordination ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # referred **Tier 4**: What are the related outcomes? % of infants who are ever breastfed **Numerator:** Infant children of program participants who were ever breastfed, between birth and six months of age. **Denominator:** Infant children of program participants. % of infants breastfeed exclusively through 6 months **Numerator:** Infant children of program participants who are breastfed exclusively from birth through six months of age **Denominator:** Infant children of program participants.
BENCHMARK DATA SOURCES	Objective # MICH-21.1: Increase the proportion of children who are ever breastfed. (Baseline: 74% in 2006, Target: 81.9%). MICH-21.2: Increase the proportion of infants who are breastfed at 6 months (Baseline: 43.5% in 2006, Target: 60.6%). MICH-21.3: Increase the proportion of infants who are breastfed at 1 year (Baseline: 34.1% in 2006, Target: 34.1%). MICH-21.4: Increase the proportion of infants who are breastfed exclusively through 3 months (Baseline: 33.6% in 2006, Target: 46.2%). MICH-21.5: Increase the proportion of infants who are breastfed exclusively at 6 months (Baseline: 14.1% in 2006, Target: 25.5%).
GRANTEE DATA SOURCES	Title V NPM #4, Home Visiting Performance Measure, Healthy Start Benchmark, Healthy People 2020, MICH-21.5, National Immunization Survey (NIS).

SIGNIFICANCE

Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal grown and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits.

PIH 3	**PERFORMANCE MEASURE**	Percent of programs promoting newborn screenings and follow-up.

Goal: Newborn Screening
Level: Grantee
Domain: Perinatal Infant Health

GOAL	To ensure supportive programming for newborn screenings.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating newborn screening and follow-up.
DEFINITION	**Tier 1**: Are you promoting and/or facilitating newborn screening and follow-up in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you promoting or facilitating newborn screening and follow-up? ☐ Technical Assistance ☐ Training ☐ Product development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Referral/ care coordination ☐ Screening/ Assessment ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # referred # receiving care coordination # assessed or screened **Tier 4**: What are the related outcomes? % of eligible newborns screened with timely notification for out of range screens **Numerator:** # of eligible newborns screened with out of range results whose caregivers receive timely notification **Denominator:** # of eligible newborns screened with out of range results % of eligible newborns screened with timely notification for out of range screens who are followed up in a timely manner **Numerator:** # of eligible newborns screened with out of range results whose caregivers receive timely notification and receive timely follow up **Denominator:** # of eligible newborns screened with out of range results whose caregivers receive timely notification
BENCHMARK DATA SOURCES	Objective # MICH-32: Increase appropriate newborn-blood spot screening and follow-up testing (Baseline: 98.3% in 2006, Target: 100%)
GRANTEE DATA SOURCES	Title V National Outcome Measure #12

SIGNIFICANCE

Newborn screening detects thousands of babies each year with potentially devastating, but treatable disorders. The benefits of newborn screening depend upon timely collection of the newborn blood-spots or administration of a point-of-care test (pulse oximeter for critical congenital heart disease), receipt of the newborn blood spot at the laboratory, testing of the newborn blood spot, and reporting out all results. Timely detecting prevents death and other significant health complications.

CH 1 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating well-child visits.
Goal 2: Well-Child Visit **Level: Grantee** **Domain: Child Health**	
GOAL	To ensure supportive programming for well-child visits.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating well-child visits.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating well-child visits in your program? Yes No **Tier 2**: Through what activities are you promoting and/ or facilitating well-child visits? ☐ Technical Assistance ☐ Training ☐ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Referral/ care coordination **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # peer-reviewed publications published # receiving information and education through outreach # referred **Tier 4**: What are the related outcomes? % of children with a well care visit in the past year **Numerator:** Program-involved children who received a well care visit in the reporting year **Denominator:** Children involved in the program in the reporting year % of children enrolled in Medicaid/ CHIP with at least one well care visit in the past year **Numerator**: Medicaid/ CHIP-enrolled children involved in the program who received a well-child visit in the reporting year. **Denominator:** Medicaid/ CHIP-enrolled children involved in the program in the reporting year
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Title V National Performance Measure #10, National Survey of Children's Health K4Q20
SIGNIFICANCE	As childhood is a time of growth and development, it is important that children are seeing their pediatrician on a regular basis.

CH 2 PERFORMANCE MEASURE **Goal 1: Quality of Well Child Visit** **Level: Grantee** **Domain: Child Health**	The percent of programs promoting and/ or facilitating quality of well-child visits.
GOAL	To ensure supportive programming for quality of well child visits.
MEASURE	The percent of MCHB funded projects promoting or facilitating quality of well child visits.
DEFINITION	**Tier 1**: Are you addressing the quality of well child visits in your program? Yes No **Tier 2**: Through what activities are you addressing quality of well child visits? □ Technical Assistance □ Training □ Product development □ Guideline setting □ Quality improvement initiatives **Tier 3**: How many are reached through those activities? # receiving TA # receiving professional/organizational development training # product disseminated # reached while guideline setting **Tier 4**: What are the related outcomes? % providers trained in conducting a quality well-child visit **Numerator:** # of providers trained **Denominator:**# of providers targeted through the program
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCE	Grantee self-reported.
SIGNIFICANCE	Children grow and develop very rapidly so it is important they see a pediatrician on a regular basis. Each visit should include a complete physical examination, record of height and weight, and information regarding hearing, vision, and annual screenings.

CH 3	**PERFORMANCE MEASURE**	Percent of programs promoting developmental screenings and follow-up for children.
Goal: Developmental Screening **Level: Grantee** **Domain: Child Health**		
GOAL		To ensure supportive programming for developmental screenings.
MEASURE		The percent of MCHB funded projects promoting and/ or facilitating developmental screening and follow-up for children.
DEFINITION		**Tier 1**: Are you promoting and/or facilitating developmental screening and follow-up in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you promoting or facilitating developmental screening and follow-up? ☐ Technical Assistance ☐ Training ☐ Product development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Referral/ care coordination ☐ Screening/ Assessment ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # referred # receiving care coordination # assessed or screened **Tier 4**: What are the related outcomes? % of children 9 through 71 months receiving a developmental screening using a parental-completed tool? **Numerator:** Children of program participants aged 9 to 71 months who have received a developmental screening using a parental/ caretaker-completed tool **Denominator:** Children, aged 9 to 71 months, of program participants
BENCHMARK DATA SOURCES		
GRANTEE DATA SOURCES		Title V National Outcome Measure #12
SIGNIFICANCE		http://ncemch.org/evidence/NPM-6-developmental-screening.php

CH 4 PERFORMANCE MEASURE **Goal 3: Injury Prevention** **Level: Grantee** **Domain: Child Health**	The percent of programs promoting and/ or facilitating injury prevention among children.
GOAL	To ensure supportive programming for injury prevention among children.
MEASURE	The percent of MCHB funded projects addressing injury prevention and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating injury prevention among children in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you addressing injury-prevention? *See data collection form.* □ Technical Assistance □ Training □ Research/ dissemination □ Peer-reviewed publications □ Outreach/ Information Dissemination/ Education □ Referral/ care coordination □ Quality improvement initiatives □ Use of fatality review data Please check which child safety domains which program activities were designed to impact: □ Motor Vehicle Traffic □ Suicide/ Self-Harm □ Falls □ Bullying □ Child Maltreatment □ Unintentional Poisoning □ Prescription drug overdose □ Traumatic Brain Injury □ Drowning □ Other **Tier 3**: How many are reached through those activities? # receiving TA # receiving professional/organizational development training # of peer-reviewed publications published # receiving information and education through outreach # referred/ managed % using fatality review data *See data collection form.* **Tier 4**: What are the related outcomes? Rate of injury-related hospitalization to children ages 1-9. **Numerator:** # of injury-related hospitalizations to children ages 1-9 **Denominator:** # of children ages 1-9 in the target population Target Population: _____ Percent of children ages 6-11 missing 5 or more days of school because of illness or injury. **Numerator:** # of children ages 6-11 missing 5 or more days of school Denominator: Total number of children ages 6-11

represented in National Survey of Children's Health results
Dataset reporting from: _____

BENCHMARK DATA SOURCES

Related to Healthy People 2020 Injury and Violence Prevention objectives 1 through 39.

GRANTEE DATA SOURCES

AHRQ Healthcare Cost and Utilization Project: National Inpatient Sample or State Inpatient Database

National Survey of Children's Health, Question G1 in the 6-11 year old survey

SIGNIFICANCE

Two dozen children die every day in the United States from an unintentional or intentional injury. In addition, millions of children survive their injury and have to live the rest of their lives with negative health effects. Although there has been much progress in the United States in reducing child injuries, more is needed.

Data Collection Form for Detail Sheet # CH 3

Please use the form below to report what services you provided in which safety domains, and how many received those services. Please use the space provided for notes to specify the recipients of each type of service.

	Motor Vehicle Traffic	Suicide/ Self-Harm	Falls	Bullying	Child Maltreatment	Unintentional Poisoning	Prescription drug overdose	Traumatic Brain Injury	Drowning	Other (Specify)
Technical Assistance										
Training										
Research/ dissemination										
Peer-reviewed publications										
Outreach/ Information Dissemination/ Education										
Referral/ care coordination										
Quality improvement initiatives										
Use of fatality review data										
Notes:										

CSHCN 1 PERFORMANCE MEASURE **Goal 1: Family Engagement** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/ or facilitating family engagement among children and youth with special health care needs.
GOAL	To ensure supportive programming for family engagement among children and youth with special health care needs.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating family engagement among children and youth with special health care needs.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating family engagement among children and youth with special health care needs in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating family engagement? Technical Assistance Training Product development Research/ Peer-reviewed publications Outreach/ Information Dissemination/ Education Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # trained # products disseminated # peer-reviewed publications published # of quality improvement initiatives # educated/ receiving information **Tier 4**: What are the related outcomes? % of target population with family and CSHCN leaders with meaningful participation on community/ state/ national level teams focused on CSHCN systems **Numerator:** # of Family and CSHCN leaders with meaningful participation on community/state/national level teams focused on CSHCN systems Denominator: # of CSHCN in catchment area % of racial and ethnic family and CSCHN leaders who are trained and serving on community/ state/ national level teams focused on CSHCN systems **Numerator:** #of racial and ethnic family and CSHCN leaders trained and serving on community/state/national level teams focused on CSHCN systems **Denominator:** # of CSHCN in catchment area % of family and CSCHN leaders trained who report increased knowledge, skill, ability and self-efficacy to serve as leaders on systems-level teams **Numerator:** # of family and CSHCN leaders trained who report increased knowledge, skill, ability and self-efficacy to serve as leaders on systems-level teams **Denominator:** # of CSHCN in catchment area

BENCHMARK DATA SOURCES	Related to Healthy People 2020 Family Planning Objectives
GRANTEE DATA SOURCES	Title V National Performance Measure #2
SIGNIFICANCE	In recent years, policy makers and program administrators have emphasized the central role of family engagement in policy-making activities. In accordance with this philosophy, MCHB is facilitating such partnerships at the local, state and national levels. While there has been a significant increase in the level and types of family engagement, there is still a need to share strategies and mechanisms to recruit, train, monitor, and evaluate family engagement as a key component for CSHCN.

CSHCN 2 PERFORMANCE MEASURE **Goal 2: Access to and Use of Medical Home** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/ or facilitating medical home access and use among children and youth with special health care needs.
GOAL	To ensure supportive programming medical home access and use among children and youth with special health care needs.
MEASURE	The percent of MCHB-funded projects promoting and/ or facilitating medical home access and use among children and youth with special health care needs.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating medical home access and use among children and youth with special health care needs? Yes No **Tier 2**: Through what processes/ mechanisms are you addressing medical home access and use? ☐ Technical Assistance ☐ Training ☐ Product development ☐ Research/ peer-reviewed publications ☐ Quality improvement initiatives ☐ Organizational policy/ framework creation ☐ Outreach/ Information Dissemination/ Education ☐ Referral/ care coordination ☐ Tracking and monitoring **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # trained # products disseminated # of publications # of quality improvement initiatives # educated/ receiving information # referred # receiving tracking and monitoring **Tier 4**: What are the related outcomes? % of target population that demonstrate a direct linkage to a coordinated medical home community as a direct result of activities conducted by project **the medical home community consists of facilitated partnerships between patients, personal physicians, specialists, ancillary services, community services and families* **Numerator:** Target population with a demonstrated direct linkage to a coordinated medical home. **Denominator:** Target population
BENCHMARK DATA SOURCES	Objective # MICH-30.2: Increase the proportion of children with special health care needs who have access to a medical home (Baseline: 47.1% in 2005-2006, Target: 51.8%)
GRANTEE DATA SOURCES	NSCH Indicator 4.8, NSCH Indicator 4.9d, Title V National Performance Measure #3

SIGNIFICANCE

Medical homes are a cultivated partnership between patients, family, and primary care providers in coordination with support from the community. These models ensure that care must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

CSHCN 3 PERFORMANCE MEASURE **Goal 3: Transition** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/or facilitating transition to adult health care for youth with special health care needs.
GOAL	To ensure supportive programming for transition to adult health care for youth with special health care needs.
MEASURE	The percent of MCHB funded projects promoting and/or facilitating transition to adult health care for youth with special health care needs.
DEFINITION	**Tier 1**: Are you addressing the transitional needs to adult health care for youth with special health care needs in your program? Yes No **Tier 2**: Through what activities are you promoting or facilitating the transition to adult health care for youth with special health care needs? ☐ Technical Assistance ☐ Training ☐ Product development ☐ Research/ peer-reviewed publications ☐ Quality improvement initiatives ☐ Organizational policy/ framework creation ☐ Outreach/ Information Dissemination/ Education ☐ Referral/ care coordination ☐ Tracking and monitoring ☐ Assessment **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # trained # products disseminated # peer-reviewed publications published # quality improvement initiatives # educated/ receiving information # referred # received tracking and monitoring # assessed for readiness **Tier 4**: What are the related outcomes? % of grantees promoting an organized framework for transitioning youth to adult health care providers and/ or integrating young adults into adult health care **Numerator:** Grantees promoting an organized framework for transitioning youth to adult health care providers **Denominator:** Total grantees reporting measure % of target population implementing an organized framework for transitioning youth to adult health care providers and/ or integrating young adults into adult health care **Numerator:** # implementing organized framework **Denominator:** # targeted with promotion of organized framework % of young adult participants assessed for readiness deemed ready to transition to adult health care providers

	Numerator: # deemed ready to transition to adult health care providers based on assessment **Denominator:** # assessed for readiness
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Title V National Performance Measure #6, NS-CSHCN Survey Outcome #6
SIGNIFICANCE	Transitioning of children to adolescent services to adult services is important to ensure that growth and development is adequately and accurately screened throughout all stages. These stages of life represent a time of rapid development and it is important to make sure changes are documented and children and receiving appropriate treatment, preventive services, and screenings.

AH 1 PERFORMANCE MEASURE **Goal 1: Adolescent Well Visit** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating adolescent well visits.
GOAL	To ensure supportive programming for adolescent well visits.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating adolescent well visits.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating adolescent well visits in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating adolescent well visits? □ Technical Assistance □ Training □ Peer-reviewed publications □ Outreach/ Information Dissemination/ Education □ Referral/ care coordination **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # referred **Tier 4**: What are the related outcomes? % of adolescents ages 12-17 with an adolescent well visit in the past year **Numerator:** Adolescents reached by the program in reporting year who had an adolescent well visit during the reporting year. **Denominator:** Adolescents reached by the program in reporting year % of 12-21 year olds enrolled in Medicaid/ CHIP with at least one adolescent well visit in the past year **Numerator:** Adolescents enrolled in Medicaid/ CHIP reached by the program in reporting year with at least one adolescent well visit in the reporting year **Denominator:** Adolescents enrolled in Medicaid/ CHIP reached by the program in reporting year
BENCHMARK DATA SOURCES	Related to Adolescent Health Objective 1: Increase the proportion of adolescent who have had a wellness checkup in the past 12 months Baseline: 68.7%, Target: 75.6%).
GRANTEE DATA SOURCES	Title V National Performance Measure 10, Adolescent Health (AH), National Vital Statistics System (NVSS) Birth File, Home Visiting
SIGNIFICANCE	Adolescence is an important period of development physically, psychologically, and socially. As adolescents move from childhood to adulthood, they are responsible for their health including annual preventive well visits which help to maintain a

healthy lifestyle, avoid damaging behaviors, manage chronic conditions, and prevent disease.

AH 2 PERFORMANCE MEASURE **Goal 2: Injury Prevention** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating adolescent injury prevention.
GOAL	To ensure supportive programming for adolescent injury prevention.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating injury prevention and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating injury prevention in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating injury-prevention? *See data collection form.* □ Technical Assistance □ Training □ Research/ dissemination □ Peer-reviewed publications □ Outreach/ Information Dissemination/ Education □ Referral/ care coordination □ Quality improvement initiatives □ Use of fatality review data Please check which child safety domains which program activities were designed to impact: □ Motor Vehicle Traffic □ Suicide/ Self-Harm □ Falls □ Bullying □ Youth Violence (other than bullying) □ Child Maltreatment □ Unintentional Poisoning □ Prescription drug overdose □ Traumatic Brain Injury □ Drowning □ Other **Tier 3**: How many are reached through those activities? # receiving TA # receiving professional/organizational development training # of peer-reviewed publications published # receiving information and education through outreach # referred/ managed % using fatality review data *See data collection form.* **Tier 4**: What are the related outcomes? Rate of injury-related hospitalization to children ages 10-19. **Numerator:** # of injury-related hospitalizations to children ages 10-19 **Denominator:** # of children ages 10-19 in the target population **Target Population:**_____ Percent of children ages 12-17 missing 11 or more days of

school because of illness or injury.

Numerator: # of children ages 12-17 missing 11 or more days of school

Denominator: Total number of children ages 12-17 represented in National Survey of Children's Health result

Dataset used: _____

BENCHMARK DATA SOURCES

Related to Healthy People Injury and Violence Prevention objectives 1 through 39.

GRANTEE DATA SOURCES

AHRQ Healthcare Cost and Utilization Project: National Inpatient Sample or State Inpatient Database

National Survey of Children's Health, 6-11 year old survey, Question G1

SIGNIFICANCE

Two dozen children die every day in the United States from an unintentional or intentional injury. In addition, millions of children survive their injury and have to live the rest of their lives with negative health effects. Although there has been much progress in the United States in reducing child injuries, more is needed.

Data Collection Form for Detail Sheet # AH 2

Please use the form below to report what services you provided in which safety domains, and how many received those services. Please use the space provided for notes to specify the recipients of each type of service.

	Motor Vehicle Traffic	Suicide/ Self-Harm	Falls	Bullying	Youth Violence (other than bullying)	Child Maltreatment	Unintentional Poisoning	Prescription drug overdose	Traumatic Brain Injury	Drowning	Other (Specify)
Technical Assistance											
Training											
Research/ dissemination											
Peer-reviewed publications											
Outreach/ Information Dissemination/ Education											
Referral/ care coordination											
Quality improvement initiatives											
Use of fatality review data											
Notes:											

AH 3 PERFORMANCE MEASURE **Goal 3: Screening for Major Depressive Disorder** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating screening for major depressive disorder.
GOAL	To ensure supportive programming for screening for major depressive disorder.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating screening for major depressive disorder for adolescents and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating screening major depressive disorder for adolescents in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you addressing injury prevention? □ Technical Assistance □ Training □ Research/ dissemination □ Peer-reviewed publications □ Outreach/ Information Dissemination/ Education □ Referral/ care coordination □ Quality improvement initiatives □ Use of fatality review data **Tier 3**: How many are reached through those activities? # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # referred/ managed % using fatality review data **Tier 4**: What are the related outcomes? % of 12-17 year olds screened for MDD in the past year in community level or school health settings **Numerator:** Adolescents aged 12 – 17 involved with your program in the reporting year who were screened for MDD in a community-level or school health setting. **Denominator:** Adolescents aged 12 – 17 involved with your program in the reporting year. % of adolescent well care visits that include screening for MDD **Numerator:** Adolescents aged 12 – 17 involved with your program in the reporting year that had a well-child that included a screening for MDD, in the reporting year. **Denominator:** Adolescents aged 12 – 17 involved with your program in the reporting year that had a well-child visit in the reporting year. % of adolescents identified with a MDD that receive treatment **Numerator:** Adolescents aged 12 – 17 involved with your program identified as having an MDD that received treatment during the reporting year **Denominator:** Adolescents aged 12 – 17 involved

with your program during the reporting year identified as having an MDD

% of adolescents with a MDD

Numerator: Adolescents aged 12 – 17 involved with your program during the reporting year identified as having an MDD

Denominator: Adolescents aged 12 – 17 involved with your program in the reporting year.

BENCHMARK DATA SOURCES

Related to Healthy People 2020 Objective MHMD-4.1. Percent of adolescents aged 12 to 17 years experienced a major depressive episode (Baseline: 8.3% in 2008, Target: 7.5%)

GRANTEE DATA SOURCES

SIGNIFICANCE

Major depression is becoming more and more common in the United States. Major depression entails interference with the ability to work, sleep, study, eat, and enjoy life. Screening for this disorder can identify individuals and effectively treat them.

LC 1 PERFORMANCE MEASURE **Goal 2: Adequate Health Insurance Coverage** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating adequate health insurance coverage.
GOAL	To ensure supportive programming for adequate health insurance coverage.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating adequate health insurance coverage.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating adequate health insurance coverage in your program? Yes No **Tier 2**: Through what activities are you promoting and/ or facilitating adequate health insurance coverage? □ Technical Assistance □ Training □ Product development □ Research/ Peer-reviewed publications □ Information Dissemination/ Education □ Outreach/ Enrollment □ Quality improvement initiatives **Tier 3**: How many are reached through those activities? # receiving TA # receiving professional/organizational development training # products disseminated # of peer-reviewed publications published # receiving information and education through outreach # referred for insurance enrollment **Tier 4**: What are the related outcomes? % with no health insurance **Numerator:** Program participants who have no health insurance during the reporting year **Denominator:** Program participants during the reporting year % with adequate health insurance in the reporting year **Numerator:** Program participants who reported having adequate insurance coverage during the reporting year **Denominator:** Program participants during the reporting year
BENCHMARK DATA SOURCES	Related to Access to Health Services Objective 1: Increase the proportion of persons with health insurance. (Baseline: 83.2% persons had medical insurance in 2008, Target: 100%)
GRANTEE DATA SOURCES	Title V National Performance Measure #15, Title V National Outcome Measure #21
SIGNIFICANCE	Individuals who acquire health insurance are more likely to have access to a usual source of care, receive well child care and immunizations, to have developmental milestones monitored, and receive prescription drugs, appropriate care for asthma and basic dental services. Insured children not only receive more timely diagnosis of serious health care conditions but experience fewer avoidable hospitalizations, improved asthma outcomes and fewer missed school days.

Data Collection form for #LC 1
Please check all population domains that you engage in each activity listed in Tier 2 related to adequate Health Insurance Coverage. For those activities or population domains that do not pertain to you, please leave them blank.

	Pregnant women	**Infants**	**Children**	**CSHCN**	**Adolescents**	**Partners/ Other Organizations**	**Providers**	**Other**
Technical Assistance								
Training								
Product Development								
Research/ Peer-reviewed publications								
Outreach/ Information Dissemination/ Education								
Referral/ care coordination								
Quality improvement initiatives								

LC 2 PERFORMANCE MEASURE **Goal 3: Tobacco and eCigarette Use** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating tobacco and eCigarette cessation.
GOAL	To ensure supportive programming promoting and/ or facilitating tobacco and eCigarette cessation.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating tobacco and eCigarette cessation, and through what processes.
DEFINITION	**Tier 1**: Are you addressing tobacco and eCigarette cessation in your program? Yes No **Tier 2**: Through what activities are you promoting and/ or facilitating tobacco and eCigarette cessation? □ Technical Assistance □ Training □ Product development □ Research/ Peer-reviewed publications □ Outreach/ Information Dissemination/ Education □ Referral/ care coordination □ Assessment/ screening □ Quality improvement initiatives **Tier 3**: How many are reached through those activities? # receiving TA # receiving professional/organizational development training # products disseminated # peer-reviewed publications published # receiving information and education through outreach # referred # receiving care coordination # assessed or screened **Tier 4**: What are the related outcomes? % of women who smoke during pregnancy **Numerator:** Program participants who were pregnant during the reporting year who smoke, use tobacco, or e-cigarette during that pregnancy **Denominator:** Program participants who were pregnant during the reporting year % of infants and children who live in households where someone smokes **Numerator:** Infants and children involved in program in reporting year who live in households in where at least one member of the household smokes, uses tobacco, or e-cigarettes **Denominator:** Infants and children involved in program in reporting year
BENCHMARK DATA SOURCES	Related to Tobacco Use Objective 6: Increase smoking cessation during pregnancy (Target: 30.0%) and related to Tobacco Use Objective 11.1L Reduce to proportion of children aged 3 to 11 years exposed to secondhand smoke (Baseline: 52.2%, Target: 47%).

GRANTEE DATA SOURCES Title V National Performance Measure #14, NSCH 12-13

SIGNIFICANCE Secondhand smoke is a mixture of mainstream smoke and the more toxic side stream smoke which is classified as a "known human carcinogen" by the US Environmental Protection Agency, the US National Toxicology Program, and the International Agency for Research on Cancer. In addition, women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby.

Data Collection form for #LC 2
Please check all population domains that you engage in each activity listed in Tier 2 related to tobacco cessation. For those activities or population domains that do not pertain to you, please leave them blank.

	Pregnant women	**Infants**	**Children**	**CSHCN**	**Adolescents**	**Partners/ Other Organizations**	**Providers**	**Other**
Technical Assistance								
Training								
Product Development								
Research/ Peer-reviewed publications								
Outreach/ Information Dissemination/ Education								
Referral/ care coordination								
Assessment/ Screening								
Quality improvement initiatives								

LC 3 PERFORMANCE MEASURE **Goal: Oral Health** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating oral health.
GOAL	To ensure supportive programming for oral health.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating oral health, and through what activities.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating oral health in your program? Yes No **Tier 2**: Through what activities are you promoting and/ or facilitating oral health? Technical Assistance Workforce Development Community Outreach Care coordination / Referral Provision of services Research/ Peer-reviewed publication **Tier 3**: How many from each population are reached through each of the activities? Pregnant women Infants Children Partners/ Other Organizations Providers Other *See data collection form.* **Tier 4**: What are the related outcomes? % of program participants receiving an oral health risk assessment **Numerator:** Number of program participants who received an oral health risk assessment in the reporting year **Denominator:** All program participants % of women in program population who had a dental visit during pregnancy **Numerator:** Program participants who were pregnant during the reporting year who had a dental visit **Denominator:** Program participants who were pregnant during the reporting year % of infants and children aged 1 through 17 who had preventative oral health visit during the last year **Numerator:** Infants and children involved with the program who received a preventative oral health visit in the reporting year **Denominator:** Infants and children involved with the program during the reporting year.
BENCHMARK DATA SOURCES	Related to Oral Health Objective 7: Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year (Baseline: 30.2%, Target: 49.0%). Related to Oral Health Objective 8: Increase the proportion of low-income children and adolescents who receive any preventive

	dental service during the past year (Baseline: 30.2%, Target: 33.2%).
GRANTEE DATA SOURCES	Title V National Performance Measure #13
SIGNIFICANCE	Oral health is a vital component of overall health. Access to oral health care, good oral hygiene and adequate nutrition are essential components of oral health to help ensure individuals achieve and maintain oral health. Those with limited preventive oral health services access are at a greater risk for oral diseases.

Data Collection Form for #LC 3

Please use the form below to identify what services you provide to each population. For those that you provide the service to, please provide the number of services provided (i.e. number of children receiving referrals), for those that you do not, please leave blank.

	Pregnant women	**Infants**	**Children**	**Adolescents**	**Partners/ Other Organizations**	**Providers**	**Other**
Technical Assistance							
Workforce Development							
Outreach/ Education							
Research/ Peer Reviewed Publication							
Referral/ Care Coordination							
Provision of Services							

CB 1 PERFORMANCE MEASURE	The percent of programs promoting and facilitating state capacity for advancing the health of MCH populations.
Goal 1: State capacity for advancing the health of MCH populations (for programs of a National scale) **Level: Grantee** **Domain: Capacity Building**	
GOAL	To ensure adequate and increasing state capacity for advancing the health of MCH populations.
MEASURE	The percent of MCHB funded projects promoting and facilitating state capacity for advancing the health of MCH populations, and through what processes.
DEFINITION	**Tier 1**: Are you promoting and facilitating state capacity for advancing the health of MCH populations for _____'s* priority topic? Yes No **prepopulated with program focus* **Tier 2**: Through what activities are you promoting and facilitating state capacity for advancing the health of MCH populations? ☐ Delivery of training on program priority topic ☐ Support state strategic planning activities ☐ Serve as expert and champion on the priority topic ☐ Facilitate state level partnerships to advance priority topics ☐ Maintain consistent state-level staffing support for priority topic (State-level programs only) ☐ Collect data to track changes in prevalence of program priority issues ☐ Utilize available data to track changes in prevalence of program priority issue on national/ regional level ☐ Issue model standards of practice for use in the clinical setting **Tier 3**: Implementation • # of professionals trained on program priority topic • How frequently are data collected and analyzed to monitor status and refine strategies?: o Less frequently than annually o Bi-annual o Quarterly o Monthly • # of MOUs between State agencies addressing priority area • # of State agencies/departments participating on priority area. This includes the following key state agencies (Check all that apply): o Commissions/ Task Forces o MCH/CSHCN o Genetics Newborn Screening o Early Hearing and Detection o EMSC o Oral Health o Developmental Disabilities o Medicaid

- Mental & Behavioral Health
- Housing
- Early Intervention/Head Start
- Education
- Child Care
- Juvenile Justice/Judicial System
- Foster Care/Adoption Agency
- Transportation
- Higher Education
- Law Enforcement
- Children's Cabinet.
- Other (Specify_____)

- Have model standards of practice been established to increase integration of MCH priority issue into clinical setting? Y/N
- Development or identification of reimbursable services codes to cover delivery of clinical services on MCH priority topic? Y/N
- Inclusion of specific language in Medicaid managed care contracts to assure coverage of payment for clinical services on MCH priority topic? Y/N

Tier 4: What are the related outcomes?

(National Programs Only)

- % of state/ jurisdictions have a strategic plan on program priority topic
- % of states/ jurisdictions receiving training on this program topic
- % of states/ jurisdictions which have state FTEs designated for this MCH topic
- % of MCH programs have an identified state lead designated on this topic
- % of states/ jurisdictions utilizing reimbursable services codes to cover delivery of clinical services on MCH priority topic?
- % of states/jurisdictions which report progress on strategic plan goals and objectives?

BENCHMARK DATA SOURCES N/A

GRANTEE DATA SOURCES Grantee Self-Reported.

CB 2	**PERFORMANCE MEASURE**	The percent of programs providing technical assistance on MCH priority topics.
Goal 2: Technical Assistance **Level: Grantee** **Domain: Capacity Building**		
GOAL		To ensure supportive programming for technical assistance.
MEASURE		The percent of MCHB funded projects providing technical assistance, on which MCH priority topics, and to whom.
DEFINITION		**Tier 1**: Are you providing technical assistance (TA) though your program? Yes No **Tier 2**: To whom are you providing TA? • Providers/ Professionals • Local/ Community partners • Title V • Other state agencies/ partners • Regional • National • International **Technical Assistant refers to collaborative problem solving on a range of issues, which may include program development, program evaluation, needs assessment, and policy or guideline formulation. It may include administrative services, site visitation, and review or advisory functions. TA may be a one-time or ongoing activity of brief or extended frequency.* **Tier 3**: How many are reached through those activities? *(populated from prior questions)* # Prenatal Care TA # Perinatal/ Postpartum Care TA # Well Woman Visit/ Preventive Health Care TA # Depression Screening TA # Severe Maternal Mortality/ Morbidity TA # Safe Sleep TA # Breastfeeding TA # Newborn Screening TA # Quality of Well Child Visit TA # Child Well Visit TA # Injury Prevention TA # Family Engagement TA # Medical Home TA # Transition TA # Adolescent Well Visit TA # Injury Prevention TA # Screening for Major Depressive Disorder TA # Health Equity TA # Adequate health insurance coverage TA # Tobacco and eCigarette Use TA # Oral Health TA # Nutrition TA # Data research and evaluation TA # Other TA (Please specify additional topics) **Tier 4**: What are the related outcomes? *(populated from prior questions)* # receiving TA

technical assistance activities
TA activities by target audience (Local, Title V, Other state agencies,/ partners, Regional, National, International)

GRANTEE DATA SOURCES Grantee self-reported.

SIGNIFICANCE National Resource Centers, Policy Centers, leadership training institutes and many other MCHB discretionary grantees provide technical assistance and training to various target audiences, including grantees, health care providers, state agencies, community-based programs, program beneficiaries, and the public as a way of improving skills, increasing the MCH knowledge base, and thus improving capacity to adequately serve the needs of MCH populations and improve their outcomes.

Data Collection Form for #CB 2
The form below will be populated by TA selected in prior measures. All measures for which a grantee reported that they provide TA will be triggered in this table.

	Participants/ Public	Providers/ Health Care workers	Community/ Local Partners	State or National Partners
Prenatal Care				
Perinatal/ Postpartum Care				
Well Woman Visit/ Preventive Health Care				
Depression Screening				
Severe Maternal Mortality/ Morbidity				
Safe Sleep				
Breastfeeding				
Newborn Screening				
Quality of Well Child Visit				
Child Well Visit				
Injury Prevention				
Family Engagement				
Medical Home				
Transition				
Adolescent Well Visit				
Injury Prevention				
Screening for Major Depressive Disorder				
Health Equity				
Adequate health insurance coverage				
Tobacco and eCigarette Use				
Oral Health				
Nutrition				
Data research and evaluation				
Other (Please specify additional topics)				

CB 3 PERFORMANCE MEASURE **Goal 3: Impact Measurement** **Level: Grantee** **Domain: Capacity Building**	The percent of grantees that collect and analyze data on the impact of their grants on the field.
GOAL	To ensure supportive programming for impact measurement.
MEASURE	The percent of grantees that collect and analyze data on the impact of their grants on the field, and the methods used to collect data.
DEFINITION	**Tier 1**: Are you collecting and analyzing data related to impact measurement in your program? Yes No **Tier 2**: How are you measuring impact? (list tools) • Conduct participant surveys • Collect client level data • Qualitative assessment • Case reports **Tier 3**: Implementation and how many are reached through those activities? • List of tools used • Outcomes of qualitative assessment • # of participant surveys • # of clients whose level data collected • # of case reports **Tier 4**: What are the related outcomes? % of grantees that collect data on the impact of their grants on the field (and methods used to collect data) **Numerator:** # of grantees that collect data on the impact of their grants on the field **Denominator:** # of grantees How is data collected:_____ % of grantees that collect and analyze data on the impact of their grants on the field (and methods used to analyze data) **Numerator:** # of grantees that analyze data on the impact of their grants on the field **Denominator:** # of grantees How is data analyzed:_____
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	

CB 4 PERFORMANCE MEASURE **Goal 4: Sustainability** **Level: Grantee** **Domain: Capacity Building**	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
GOAL	To ensure sustainability of programs or initiatives over time, beyond the duration of MCHB funding.
MEASURE	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding, and through what methods.
DEFINITION	**Tier 1**: Are you addressing sustainability in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you addressing sustainability? □ A written sustainability plan is in place within two years of the MCHB award with goals, objectives, action steps, and timelines to monitor plan progress □ Staff and leaders in the organization engage and build partnerships with consumers, and other key stakeholders in the community, in the early project planning, and I sustainability planning and implementation processes □ There is support for the MCHB-funded program or initiative within the parent agency or organization, including from individuals with planning and decision making authority □ There is an advisory group or a formal board that includes family, community and state partners, and other stakeholders who can leverage resources or otherwise help to sustain the successful aspects of the program or initiative □ The program's successes and identification of needs are communicated within and outside the organization among partners and the public, using various internal communication, outreach, and marketing strategies □ The grantee identified, actively sought out, and obtained other funding sources and in-kind resources to sustain the entire MCHB-funded program or initiative □ Policies and procedures developed for the successful aspects of the program or initiative are incorporated into the parent or another organization's system of programs and services □ The responsibilities for carrying out key successful aspects of the program or initiative have begun to be transferred to permanent staff positions in other ongoing programs or organizations □ The grantee has secured financial or in-kind support from within the parent organization or external organizations to sustain the successful aspects of the MCHB-funded program or initiative **Tier 3**: How many are reached through those activities? N/A **Tier 4**: What are the related outcomes? % of grants that have sustainability plans
BENCHMARK DATA SOURCES	

GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	In recognition of the increasing call for recipients of public funds to sustain their programs after initial funding ends, MCHB encourages grantees to work toward sustainability throughout their grant periods. A number of different terms and explanations have been used as operational components of sustainability. These components fall into four major categories, each emphasizing a distinct focal point as being at the heart of the sustainability process: (1) adherence to program principles and objectives, (2) organizational integration, (3) maintenance of health benefits, and (4) State or community capacity building. Specific recommended actions that can help grantees build toward each of these four sustainability components are included as the Tier 2 data elements for this measure.

CB 5 PERFORMANCE MEASURE **Goal 5: Scientific Publications** **Level: Grantee** **Domain: Capacity Building**	The percent of programs supporting the production of scientific publications and through what means, and related outcomes.
GOAL	To ensure supportive programming for the production of scientific publications.
MEASURE	The percent of MCHB funded projects programs supporting the production of scientific publications.
DEFINITION	**Tier 1**: Are you supporting the production of scientific publications in your program? Yes No **Tier 2**: Through what processes/ mechanisms are you supporting the production of scientific publications? Type of article: • Submitted • In press **Tier 3**: How many are reached through those activities? # of scientific/ peer-reviewed publications **Tier 4**: What are the related outcomes? Dissemination vehicles (Note: research only; include this as Part B of publications form) • TV/ Radio interviews • Newspaper interview • Press release • Social/ Networking sites • Listservs • Presentation at conference (poster, abstract, presentation)
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Advancing the field of MCH based on evidence-based, field-tested quality products. Collection of the types of and dissemination of MCH products and publications is crucial for advancing the field. This measure addresses the production and quality of new informational resources created by grantees for families, professionals, other providers, and the public.

CB 6 PERFORMANCE MEASURE **Goal 6: Products** **Level: Grantee** **Domain: Capacity Building**	The percent of programs supporting the development of informational products and through what means, and related outcomes.
GOAL	To ensure supportive programming for the development of informational products.
MEASURE	The percent of MCHB funded projects supporting the development of informational products, and through what processes.
DEFINITION	**Tier 1**: Are you producing products as part of your MCHB-supported program? Yes No **Tier 2**: Indicate the categories of products that have been produced with grant support during the reporting period. *Count the original completed product, not each time it is disseminated or presented.* □ Books □ Book chapters □ Reports and monographs (including policy briefs, best practice reports, white papers) □ Conference presentations and posters presented □ Web-based products (website, blogs, webinars, newsletters, distance learning modules, wikis, RSS feeds, social networking sites) *Excluding video/ audio products that are posted online post-production* □ Audio/ Video products (podcasts, produced videos, video clips.CD-ROMs, CDs, or audio) □ Press communications (TV/ Radio interviews, newspaper interviews, public service announcements, and editorial articles) □ Newsletters (electronic or print) □ Pamphlets, brochures, or fact sheets □ Academic course development □ Distance learning modules □ Doctoral dissertations/ Master's theses □ Other **Tier 3**: How many are reached through those activities? # products in each category **Tier 4**: What are the related outcomes? N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Advancing the field of MCH based on evidence-based, field-tested quality products. Collection of the types of and dissemination of MCH products and publications is crucial for advancing the field. This PM addresses the production and quality of new informational resources created by grantees for families, professionals, other providers, and the public.

Core 1 PERFORMANCE MEASURE **Goal: Grant Impact** **Level: Grantee** **Domain: Core**	The percent of programs meeting the stated aims of their grant at the end of the current grant cycle
GOAL	To ensure that planned grant impact was met.
MEASURE	The percent of MCHB funded projects meeting their stated objectives.
DEFINITION	**Tier 1**: Have you met the planned objectives as stated at the beginning of the grant cycle? *Prepopulated with the objectives from FOA:* • Did you meet objective 1_____? Y/N • Did you meet objective 2_____? Y/N
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported
SIGNIFICANCE	

Core 2 PERFORMANCE MEASURE **Goal 2: Quality Improvement** **Level: Grantee** **Domain: Core**	The percent of programs engaging in quality improvement and through what means, and related outcomes.
GOAL	To measure quality improvement initiatives.
MEASURE	The percent of MCHB funded projects implementing quality improvement initiatives.
DEFINITION	**Tier 1**: Are you implementing quality improvement (QI) initiatives in your program? Yes No **Tier 2**: QI initiative: What type of QI structure do you have? □ Team established within a division, office, department, etc. of an organization to improve a process, policy, program, etc. □ Team within and across an organization focused on organizational improvement □ Cross sectorial collaborative across multiple organizations What types of aims are included in your QI initiative? □ Population health □ Improve service delivery (process or program) □ Improve client satisfaction □ Improve work flow □ Policy improvement □ Reducing variation or errors **Tier 3**: Implementation Are QI goals directly aligned with organization's strategic goals? Y/ N Has the QI team received training in QI? Y/N Do you have metrics to track improvement? Y/N Which methodology are you utilizing for quality improvement? □ Plan, Do, Study, Act Cycles □ Lean □ Six Sigma □ Other: _____ **Tier 4**: What are the related outcomes? Is there data to support improvement in population health as a result of the QI activities? Y/N Is there data to support organizational improvement as a result of QI activities? Y/N
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	

Core 3 PERFORMANCE MEASURE **Goal 1: Health Equity** **Level: Grantee** **Domain: Life Course/ Cross cutting**	The percent of programs promoting and/ or facilitating improving health equity.
GOAL	To ensure MCHB grantees have established specific aims related to improving health equity.
MEASURE	The percent of MCHB funded projects with specific measurable aims related to promoting health equity.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating health equity in your program? Yes No **Tier 2**: Please select within which of the following domains your program addresses health equity: □ Income □ Race □ Ethnicity □ Language □ Disability □ Sexual Orientation □ Sex □ Gender □ Geography – Rural/ Urban **Tier 3**: Implementation Has your program set stated goal/ objectives for health equity? Y/N If yes, what are those aims? **Tier 4**: What are the related outcomes? % of programs that met stated goals/ objectives around health equity **Numerator:** # of programs that met stated specific aims around health equity **Denominator:** # of programs that set specific aims around health equity
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Health equity is achieved when every individual has the opportunity to attain his or her full health potential and no one is "disadvantaged from achieving this potential because of social position or socially determined consequences." Achieving health equity is a top priority in the United States.

Table 1: Activity Data Collection Form for Selected Measures (PROPOSED)
Please use the form below to identify what services you provide to each segment. For those you provide the service to, please provide the number of services provided (i.e. # of women receiving referrals or # of partners receiving TA). For those services you do not provide, or segments you do not reach, please leave the cell blank.

	Consumers/ Population	Providers/ Professionals	Community Partners	State or National Agencies
Technical Assistance				
Training				
Product Development				
Research/ Peer-reviewed publications				
Outreach/ Information Dissemination/ Education				
Screening/ Assessment				
Referral/ care coordination				
Direct Service				
Quality improvement initiatives				

DIVISION OF MCH WORKFORCE DEVELOPMENT: PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

Performance Measure	New/Revised Measure	Prior PM Number (if applicable)	Topic
Training 1	New	N/A	MCH Training Program Family Member/Youth/Community Member participation
Training 2	New	N/A	MCH Training Program Cultural Competence
Training 3	New	N/A	Healthy Tomorrows Title V Collaboration
Training 4	New	N/A	MCH Pipeline Program – Work with MCH populations
Training 5	New	N/A	MCH Pipeline Program – Work with underserved or vulnerable populations
Training 6	Revised	08	Leadership
Training 7	Revised	09	Diversity of Long-Term Trainees
Training 8	Revised	59	Title V Collaboration
Training 9	Revised	60	Interdisciplinary Practice
Training 10	No changes	64	Diverse Adolescent Involvement (LEAH-specific)
Training 11	Revised	83	MCH Pipeline - Graduate Program Enrollment
Training 12	Revised	84	Work with MCH Populations
Training 13	Revised	85	Policy
Training 14	Revised	86	Medium-Term Trainees Skill and Knowledge (PPC-Specific)

Training 01 PERFORMANCE MEASURE **Goal: Family/ Youth/ Community Engagement in MCH Training Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB training programs that ensure family, youth, and community member participation in program and policy activities.
GOAL	To increase family/ youth/ community member participation in MCH Training programs.
MEASURE	The percent of MCHB training programs that ensure family/ youth/ community member participation in program and policy activities.
DEFINITION	Attached is a table of five elements that demonstrate family member/youth/community member participation, including an emphasis on partnerships and building leadership opportunities for family members/youth/community members in MCH Training programs. Please check yes or no to indicate if your training program has met each element.
BENCHMARK DATA SOURCES	PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula
GRANTEE DATA SOURCES	Attached data collection form is to be completed by grantees.
SIGNIFICANCE	Over the last decade, policy makers and program administrators have emphasized the central role of families and other community members as advisors and participants in program and policy-making activities. In accordance with this philosophy, MCH Training Programs are facilitating such partnerships at the local, State and national levels. MCH Training programs support interdisciplinary/interprofessional graduate education and training programs that emphasize leadership, and family-centered, community-based, and culturally competent systems of care. Training programs are required to incorporate family members/youth/community members as faculty, trainees, and partners.

DATA COLLECTION FORM FOR DETAIL SHEET #XX

Please indicate if your MCH Training program has included family members/youth/community members in each of the program elements listed below. Use the space provided for notes to provide additional details about activities, as necessary.

Element	No	Yes
1. **Participatory Planning** Family members/youth/community member participate in and provide feedback on the planning, implementation and/or evaluation of the training program's activities (e.g. strategic planning, program planning, materials development, program activities, and performance measure reporting).		
2. **Cultural Diversity** Culturally diverse family members/youth/community members facilitate the training program's ability to meet the needs of the populations served.		
3. **Leadership Opportunities** Within your training program, family members/youth/community member are offered training, mentoring, and/or opportunities for leadership roles on advisory committees or task forces.		
4. **Compensation** Family members/youth/community member who participate in the MCH Training program are paid staff, consultants, or compensated for their time and expenses.		
5. **Train MCH/CSHCN staff** Family members/youth/community members work with their training program to provide training (pre-service, in-service and professional development) to MCH/CSHCN staff and providers.		

NOTES/COMMENTS:

Training 02 PERFORMANCE MEASURE **Goal: Cultural Competence in MCH Training Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB training programs that have incorporated cultural and linguistic competence elements into their policies, guidelines, and training.
GOAL	To increase the percentage of MCH Training programs that have integrated cultural and linguistic competence into their policies, guidelines, and training.
MEASURE	The percent of MCHB training programs that have integrated cultural and linguistic competence into their policies, guidelines, and training.
DEFINITION	Attached is a checklist of 6 elements that demonstrate cultural and linguistic competency. Please check yes or no to indicate if your MCH Training program has met each element. Please keep the completed checklist attached. Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989; cited from National Center for Cultural Competence (http://nccc.georgeto wn.edu/foundations/frameworks.html) Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this

	capacity. (Goode, T. and W. Jones, 2004. National Center for Cultural Competence; http://www.nccccurricula.info/linguisticcompetence.html) Cultural and linguistic competency is a process that occurs along a developmental continuum. A culturally and linguistically competent program is characterized by elements including the following: written strategies for advancing cultural competence; cultural and linguistic competency policies and practices; cultural and linguistic competence knowledge and skills building efforts; research data on populations served according to racial, ethnic, and linguistic groupings; faculty and other instructors are racially and ethnically diverse; faculty and staff participate in professional development activities related to cultural and linguistic competence; and periodic assessment of trainees' progress in developing cultural and linguistic competence.
BENCHMARK DATA SOURCES	Related to the following HP2020 Objectives: PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula PHI-12: Increase the proportion of public health laboratory systems (including State, Tribal, and local) which perform at a high level of quality in support of the 10 Essential Public Health Services ECBP-11: Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs
GRANTEE DATA SOURCES	Attached data collection form is to be completed by grantees. There is no existing national data source to measure the extent to which MCHB supported programs have incorporated cultural competence elements into their policies, guidelines, and training.
SIGNIFICANCE	Over the last decade, researchers and policymakers have emphasized the central influence of cultural values and cultural/linguistic barriers: health seeking behavior, access to care, and racial and ethnic

disparities. In accordance with these concerns, cultural competence objectives have been: (1) incorporated into the Division of MCH Workforce Development strategic plan; and (2) in guidance materials related to the MCH Training Programs.
The Division of MCH Workforce Development provides support to programs that address cultural and linguistic competence through development of curricula, research, learning and practice environments

DATA COLLECTION FORM FOR DETAIL SHEET #Training 02

Please indicate if your MCH Training program has incorporated the following cultural/linguistic competence elements into your policies, guidelines, and training.

Please use the space provided for notes to provide additional details about the elements, as applicable.

Element	Yes 1	No 0
1. **Written Guidelines** Strategies for advancing cultural and linguistic competency are integrated into your training program's written plan(s) (e.g., grant application, recruiting plan, placement procedures, monitoring and evaluation plan, human resources, formal agreements, etc.).		
2. **Training** Cultural and linguistic competence knowledge and skills building are included in training aspects of your program.		
3. **Data** Research or program information gathering includes the collection and analysis of data on populations served according to racial, ethnic, and linguistic groupings, where appropriate.		
4. **Staff/faculty diversity** MCH Training Program staff and faculty reflect cultural and linguistic diversity of the significant populations served.		
5. **Professional development** MCH Training Program staff and faculty participate in professional development activities to promote their cultural and linguistic competence.		
6. **Measure progress** A process is in place to assess the progress of MCH Training program participants in developing cultural and linguistic competence.		

NOTES/COMMENTS*:*

Training 03 PERFORMANCE MEASURE **Goal: Healthy Tomorrow's Partnership** **Level: Grantee** **Domain: MCH Workforce Development**	The degree to which the Healthy Tomorrow's Partnership for Children program collaborates with State Title V agencies, other MCH or MCH-related programs.
GOAL	To assure that the Healthy Tomorrows program has collaborative interactions related to professional development, policy development and product development and dissemination with relevant national, state and local MCH programs, agencies and organizations.
MEASURE	The degree to which a Healthy Tomorrows program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations.
DEFINITION	Attached is a list of the 7 elements that describe activities carried out by Healthy Tomorrows programs for or in collaboration with State Title V and other agencies on a scale of 0 to 1 (0=no; 1=yes). If a value of '1' (yes) is selected, provide the number of activities for the element. The total score for this measure will be determined by the sum of those elements noted as '1.'
BENCHMARK DATA SOURCES	ECBP-11(Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs … ECPB-2: Increase the proportion of elementary, middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems. ECBP-12 Increase the inclusion of core clinical prevention and population health content in M.D.-granting medical schools. ECBP-13: Increase the inclusion of core clinical prevention and population health content in in D.O.-granting medical schools. ECBP-15: Increase the inclusion of core clinical prevention and population health content in in nurse practitioner training. ECBP-17: Increase the inclusion of core clinical prevention and population health content in in Doctor of Pharmacy (PharmD) granting colleges and schools of pharmacy PHI-2(Developmental) Increase the proportion of Tribal, State, and local public health personnel who receive continuing education

consistent with the Core Competencies for Public Health Professionals

GRANTEE DATA SOURCES

The Healthy Tomorrows program completes the attached table which describes the categories of collaborative activity.

SIGNIFICANCE

As a SPRANS grantee, a training program enhances the Title V State block grants that support the MCHB goal to promote comprehensive, coordinated, family-centered, and culturally-sensitive systems of health care that serve the diverse needs of all families within their own communities. Interactive collaboration between a training program and Federal, Tribal, State and local agencies dedicated to improving the health of MCH populations will increase active involvement of many disciplines across public and private sectors and increase the likelihood of success in meeting the goals of relevant stakeholders.

This measure will document a Healthy Tomorrows program's abilities to:

1) collaborate with State Title V and other agencies (at a systems level) to support achievement of the MCHB Strategic Goals and Healthy People 2020 action plan;
2) make the needs of MCH populations more visible to decision-makers and can help states achieve best practice standards for their systems of care; internally use this data to assure a full scope of these program elements in all regions.

DATA COLLECTION FORM FOR DETAIL SHEET:
PM #Training 03 for Healthy Tomorrows Programs

Indicate the degree to which the Health Tomorrow's program collaborates with State Title V (MCH Block Grant) agencies and other MCH-related programs***** using the following values:
0= Does not collaborate on this element 1= Does collaborate on this element.

If your program does collaborate, provide the total number of activities for the element.

Element	State Title V Agencies[1]			Other MCH-related programs[2]		
	0	1	Total number of	0	1	Total number of activities
1. Advisory Committee Examples might include: having representation from State Title V or other MCH program on your advisory						
2. Professional Development & Training Examples might include: collaborating with state Title V agency to develop state training activity						
3. Policy Development Examples might include: working with State Title V agency to develop and pass legislation						
4. Research, Evaluation, and Quality Improvement Examples might include: working with MCH partners on quality improvement efforts						
5. Product Development Examples might include: participating on collaborative with MCH partners to develop community materials						
6. Dissemination Examples might include: disseminating information on program implementation to local MCH partners						
7. Sustainability Examples might include: working with state and local MCH representatives to develop sustainability plans						
Total						

[1]State Title V programs include State Block Grant funded or supported activities.
[2]Other maternal and child health-related programs (both MCHB-funded and funded from other sources) include, but are not limited to:

- State Health Department
- State Adolescent Health
- Social Service Agency
- Medicaid Agency
- Education
- Juvenile Justice
- Early Intervention
- Home Visiting
- Professional Organizations/Associations
- Family and/or Consumer Group
- Foundations
- Clinical Program/Hospitals
- Local and state division of mental health
- Developmental disability agencies
- Other programs working with maternal and child health

Training 04 PERFORMANCE MEASURE **Goal: MCH Pipeline Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB Pipeline Program graduates who are engaged in work focused on MCH populations.
GOAL	To increase the percent of graduates of MCH Pipeline Programs who are engaged in work focused on MCH populations.
MEASURE	The percent of MCHB Pipeline Program graduates who are engaged in work focused on MCH populations.
DEFINITION	**Numerator**: Number of pipeline graduates reporting they are engaged in work focused on MCH populations. **Denominator**: The total number of trainees responding to the survey **Units:** 100 **Text:** Percent MCH Pipeline trainees are defined as undergraduate students from economically and educationally disadvantaged backgrounds (including underrepresented racial and ethnic minorities: African American, Hispanic/Latino, Asian, Hawaiian/Pacific Islanders, American Indian/Alaskan) who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related fields **MCH Populations**: Includes women, infants and children, adolescents, young adults, and their families including fathers, and children and youth with special health care needs
BENCHMARK DATA SOURCES	Related to Healthy People 2020: Access Goal: Improve access to comprehensive, high-quality health care services Educational Community Based Program Goal: Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health and enhance quality of life. Specific objectives: 10-11 Related to Public Health Infrastructure: To ensure that Federal, Tribal, State, and local health agencies have the necessary infrastructure to effectively provide essential public health services. Specific objectives: 2, 3, and 5

GRANTEE DATA SOURCES	A pipeline program follow-up survey will be used to collect these data. Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Pillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885. Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA.* 2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154)
SIGNIFICANCE	HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care.

DATA COLLECTION FORM - MCH PIPELINE PROGRAM

MCH Pipeline Program graduates who report working with **the maternal and child health population** (i.e., women, infants, children, adolescents, young adults, and their families, including and children with special health care needs) 2 years and 5 years after graduating from their MCH Pipeline program.

NOTE: If the individual works with more than one of these groups only count them once.

2 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

A. The total number of graduates, 2 years following completion of program _____

B. The total number of graduates lost to follow-up _____

C. The total number of respondents (A-B) = denominator _____

D. Number of respondents who report working with an MCH population _____

E. Percent of respondents who report working with an MCH population _____

5 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

A. The total number of graduates, 5 years following completion of program _____

B. The total number of graduates lost to follow-up _____

C. The total number of respondents (A-B) = denominator _____

D. Number of respondents who report working with an MCH population _____

E. Percent of respondents who report working with an MCH population _____

Training 05 PERFORMANCE MEASURE **Goal: MCH Pipeline Program** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCH Pipeline Program graduates who are engaged in work with populations considered to be underserved or vulnerable.
GOAL	To increase the percent of graduates of MCH Pipeline Programs who are engaged in work with populations considered to be underserved or vulnerable.
MEASURE	The percent of MCH Pipeline Program graduates who are engaged in work with populations considered to be underserved or vulnerable.
DEFINITION	**Numerator:** Number of pipeline graduates reporting they are engaged in work with populations considered underserved or vulnerable. **Denominator**: The total number of trainees responding to the survey **Units**: 100 **Text**: Percent MCH Pipeline trainees are defined as undergraduate students from economically and educationally disadvantaged backgrounds (including underrepresented racial and ethnic minorities: African American, Hispanic/Latino, Asian, Hawaiian/Pacific Islanders, American Indian/Alaskan) who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related fields The term “underserved” refers to “Medically Underserved Areas and Medically Underserved Populations with shortages of primary medical care, dental or mental health providers. Populations may be defined by geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services) factors. The term "vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and

	diminished quality of life. (i.e, Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, etc) *Source: Center for Vulnerable Populations Research. UCLA. http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html*
BENCHMARK DATA SOURCES	Related to Healthy People 2020: Access Goal: Improve access to comprehensive, high-quality health care services Educational Community Based Program Goal: Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health and enhance quality of life. Specific objectives: 10-11 Related to Public Health Infrastructure: To ensure that Federal, Tribal, State, and local health agencies have the necessary infrastructure to effectively provide essential public health services. Specific objectives: 2, 3, and 5
GRANTEE DATA SOURCES	A pipeline program follow-up survey will be used to collect these data. Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Pillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885. Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA.* 2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154)
SIGNIFICANCE	HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care.

DATA COLLECTION FORM – PM # Training 05 - MCH PIPELINE PROGRAM

MCH Pipeline Program graduates who report engaging in work with populations considered **underserved or vulnerable** 2 years and 5 years after graduating from their MCH Pipeline program.

NOTE: If the individual works with more than one of these groups only count them once.

2 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

A. The total number of graduates, 2 years following completion of program

_____

B. The total number of graduates lost to follow-up

_____

C. The total number of respondents (A-B) = denominator

_____

D. Number of respondents who report working with populations considered to be underserved or vulnerable

_____

E. Percent of respondents who report working with populations considered to be underserved or vulnerable

_____

5 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

A. The total number of graduates, 5 years following completion of program

_____

B. The total number of graduates lost to follow-up

_____

C. The total number of respondents (A-B) = denominator

_____

Number of respondents who report working with populations considered to be underserved or vulnerable

_____

E. Percent of respondents who report working with populations considered to be underserved or vulnerable

_____

Training 06 PERFORMANCE MEASURE **Goal: Field Leadership** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of long term trainees that demonstrate field leadership after completing an MCH training program.
GOAL	To increase the percentage of long term trainees that demonstrate field leadership two and five years after completing their MCH Training Program.
MEASURE	The percentage of long-term trainees that demonstrate field leadership after completing an MCH Training Program.
DEFINITION	Attached is a checklist of four elements that demonstrate field leadership. For each element, identify the number of long-term trainees that demonstrate field leadership two and five years after program completion. Please keep the completed checklist attached. Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) MCH training program, including those who received MCH funds and those who did not. "Field leadership" refers to but is not limited to providing MCH leadership within the clinical, advocacy, academic, research, public health, public policy or governmental realms. Refer to attachment for complete definition. Cohort is defined as those who have completed an MCHB-funded training program 2 years and 5 years prior to the reporting period. Data form for each cohort year will be collected for five years.
BENCHMARK DATA SOURCES	Related to Objectives: ECBP-12 Increase the inclusion of core clinical prevention and population health content in M.D.-granting medical schools. ECBP-13: Increase the inclusion of core clinical prevention and population health content in in D.O.-granting medical schools. ECBP-15: Increase the inclusion of core clinical prevention and population health content in in nurse practitioner training. ECBP-17: Increase the inclusion of core clinical prevention and population health content in in Doctor of Pharmacy (PharmD) granting colleges and schools of pharmacy

	PHI-2(Developmental) Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals.
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantees.
SIGNIFICANCE	An MCHB trained workforce is a vital participant in clinical, administrative, policy, public health and various other arenas. MCHB long term training programs assist in developing a public health workforce that addresses MCH concerns and fosters field leadership in the MCH arena.

DATA COLLECTION FORM FOR DETAIL SHEET PM #Training 06
SECTION A: 2 YEAR FOLLOW-UP

Numerator: The number of long-term trainees who demonstrate field leadership **2 years** after completing their MCH Training Program.

Denominator: The total number of long-term trainees, **2 years** following completion of an MCHB-funded training program, included in this report.

Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) MCH training program, including those who received MCH funds and those who did not.

A. The total number of long-term trainees, **2 years** post program completion, included in this report _____

B. The total number of program completers lost to follow-up _____

C. Number of respondents (A-B) _____

D. Number of respondents demonstrating field leadership in **at least** one of the following areas below _____

E. Percent of long-term trainees (**2 years** post program completion) demonstrating MCH leadership in **at least one** of the following areas: _____

(Individual respondents may have leadership activities in multiple areas below)

1. Number of trainees that have participated in **academic** leadership activities _____
   - Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
   - Conducted research or quality improvement on MCH issues
   - Provided consultation or technical assistance in MCH areas
   - Taught/mentored in my discipline or other MCH related field
   - Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
   - Procured grant and other funding in MCH areas
   - Conducted strategic planning or program evaluation

2. Number of trainees that have participated in **clinical** leadership activities _____
   - Participated as a group leader, initiator, key contributor or in a position of influence/authority on any of the following: committees of State, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
   - Served in a clinical position of influence (e.g. director, senior therapist, team leader, etc

- Taught/mentored in my discipline or other MCH related field
- Conducted research or quality improvement on MCH issues
- Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)

3. Number of trainees that have participated in **public health practice** leadership activities _____

- Provided consultation, technical assistance, or training in MCH areas
- Procured grant and other funding in MCH areas
- Conducted strategic planning or program evaluation
- Conducted research or quality improvement on MCH issues
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- Participated in public policy development activities (e.g., Participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation (provided testimony, educated legislators, etc)

4. Number of trainees that have participated in **public policy & advocacy** leadership activities _____

- Participated in public policy development activities (e.g., participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation, provided testimony, educated legislators)
- Participated on any of the following as a group leader, initiator, key contributor, or in a position of influence/authority: committees of State, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
- Disseminated information on MCH public policy issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)

_____

SECTION B: 5 YEAR FOLLOW-UP

Numerator: The number of long-term trainees who demonstrate field leadership **5 years** after completing their MCH Training Program.

Denominator: The total number of long-term trainees, **5 years** following completion of an MCHB-funded training program, included in this report.

Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) MCH training program, including those who received MCH funds and those who did not.

F. The total number of long-term trainees, **5 years** post program completion, included in this report _____

G. The total number of program completers lost to follow-up _____

H. Number of respondents (A-B) _____

I. Number of respondents demonstrating field leadership in **at least** one of the following areas below _____

J. Percent of long-term trainees (**5 years** post program completion) demonstrating MCH leadership in **at least one** of the following areas: _____

(Individual respondents may have leadership activities in multiple areas below)

1. Number of trainees that have participated in **academic** leadership activities _____

- Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
- Conducted research or quality improvement on MCH issues
- Provided consultation or technical assistance in MCH areas
- Taught/mentored in my discipline or other MCH related field
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- Procured grant and other funding in MCH areas
- Conducted strategic planning or program evaluation

2. Number of trainees that have participated in **clinical** leadership activities _____

- Participated as a group leader, initiator, key contributor or in a position of influence/authority on any of the following: committees of State, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
- Served in a clinical position of influence (e.g. director, senior therapist, team leader, etc
- Taught/mentored in my discipline or other MCH related field
- Conducted research or quality improvement on MCH issues
- Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key

presentations, training manuals, issue briefs, best practices documents, standards of care)
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)

3. Number of trainees that have participated in **public health practice** leadership activities _____

- Provided consultation, technical assistance, or training in MCH areas
- Procured grant and other funding in MCH areas
- Conducted strategic planning or program evaluation
- Conducted research or quality improvement on MCH issues
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- Participated in public policy development activities (e.g., Participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation (provided testimony, educated legislators, etc)

4. Number of trainees that have participated in **public policy & advocacy** leadership activities _____

- Participated in public policy development activities (e.g., participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation, provided testimony, educated legislators)
- Participated on any of the following as a group leader, initiator, key contributor, or in a position of influence/authority: committees of State, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
- Disseminated information on MCH public policy issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)

NOTES/COMMENTS:

Training 07 PERFORMANCE MEASURE **Goal: Long Term Training Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
GOAL	To increase the percentage of trainees participating in MCHB long-term training programs who are from underrepresented racial and ethnic groups..
MEASURE	The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
DEFINITION	**Numerator:** Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs reported to be from underrepresented racial and ethnic groups. (Include MCHB-supported and non-supported trainees.) **Denominator**: Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs. (Include MCHB-supported and non-supported trainees.) **Units:** 100 **Text:** Percentage The definition of "underrepresented racial and ethnic groups" is based on the categories from the U.S. Census.
BENCHMARK DATA SOURCES	Related to Healthy People 2020 Objectives: AHS-4: Increase the number of practicing primary care providers ECBP-11: (Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs
GRANTEE DATA SOURCES	Data will be collected annually from grantees about their trainees. MCHB does not maintain a master list of all trainees who are supported by MCHB long-term training programs. References supporting Workforce Diversity: ● In the Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce (2004). Institute of Medicine. ● Unequal Treatment: Confronting

Racial and Ethnic Disparities in Health Care (2002). Institute of Medicine.

SIGNIFICANCE

HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. Training a diverse group of professionals is necessary in order to provide a diverse public health workforce to meet the needs of the changing demographics of the U.S. and to ensure access to culturally competent and effective services. This performance measure provides the necessary data to report on HRSA's initiatives to reduce health disparities.

Data Collection Form For Detail Sheet #Training 07

Report on the percentage of long-term trainees (≥300 contact hours) who are from any underrepresented racial/ethnic group (i.e., Hispanic or Latino, American Indian or Alaskan Native, Asian, Black or African-American, Native Hawaiian or Pacific Islander, two or more race (OMB). Please use the space provided for notes to detail the data source and year of data used.

- ▲ Report on all long-term trainees (≥ 300 contact hours) including MCHB-funded and non MCHB-funded trainees
- ▲ Report race and ethnicity separately
- ▲ Trainees who select multiple ethnicities should be counted once
- ▲ Grantee reported numerators and denominator will be used to calculate percentages

Total number of long term trainees (≥ 300 contact hours) participating in the training program. (Include MCHB-supported and non-supported trainees.) _____

Ethnic Categories

Number of long-term training participants who are Hispanic or Latino (Ethnicity) _____

Racial Categories

Number of long-term trainees who are American Indian or Alaskan Native _____

Number of long-term trainees who are of Asian descent _____

Number of long-term trainees who are Black or African-American _____

Number of long-term trainees who are Native Hawaiian or Pacific Islanders _____

Number of long-term trainees who are two or more races _____

Notes/Comments:

Training 08 PERFORMANCE MEASURE **Goal: Collaborative Interactions** **Level: Grantee** **Domain: MCH Workforce Development**	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.
GOAL	To assure that a training program has collaborative interactions related to training, technical assistance, continuing education, and other capacity-building services with relevant national, state and local programs, agencies and organizations.
MEASURE	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations.
DEFINITION	Attached is a list of the 6 elements that describe activities carried out by training programs for or in collaboration with State Title V and other agencies on a scale of 0 to 1. If a value of '1' is selected, provide the number of activities for the element. The total score for this measure will be determined by the sum of those elements noted as '1.'
BENCHMARK DATA SOURCES	ECBP-11(Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs … ECPB-2: Increase the proportion of elementary, middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems. ECBP-12 Increase the inclusion of core clinical prevention and population health content in M.D.-granting medical schools. ECBP-13: Increase the inclusion of core clinical prevention and population health content in in D.O.-granting medical schools. ECBP-15: Increase the inclusion of core clinical prevention and population health content in in nurse practitioner training. ECBP-17: Increase the inclusion of core clinical prevention and population health content in in Doctor of Pharmacy (PharmD) granting colleges and schools of pharmacy PHI-2(Developmental) Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals

GRANTEE DATA SOURCES

The training program completes the attached table which describes the categories of collaborative activity.

SIGNIFICANCE

As a SPRANS grantee, a training program enhances the Title V State block grants that support the MCHB goal to promote comprehensive, coordinated, family-centered, and culturally-sensitive systems of health care that serve the diverse needs of all families within their own communities. Interactive collaboration between a training program and Federal, Tribal, State and local agencies dedicated to improving the health of MCH populations will increase active involvement of many disciplines across public and private sectors and increase the likelihood of success in meeting the goals of relevant stakeholders.

This measure will document a training program's abilities to:

1) collaborate with State Title V and other agencies (at a systems level) to support achievement of the MCHB Strategic Goals and CSHCN Healthy People 2010 action plan;
2) make the needs of MCH populations more visible to decision-makers and can help states achieve best practice standards for their systems of care; and
3) internally use this data to assure a full scope of these program elements in all regions.

DATA COLLECTION FORM FOR DETAIL SHEET PM #Training 08

Indicate the degree to which your training program collaborates with State Title V (MCH Block Grant) agencies and other MCH-related programs***** using the following values:
0= Does not collaborate on this element 1= Does collaborate on this element.
If your program does collaborate, provide the total number of activities for the element.

Element	**State Title V programs[1]**			**Other MCH-related programs[2]**		
	0	1	Total number of activities	0	1	Total number of activities
Service Examples might include: Clinics run by the training program and/ or in collaboration with other agencies						
Training Examples might include: Training in Bright Futures; Workshops related to adolescent health practice; and Community-based practices. It would not include clinical supervision of long-term trainees.						
Continuing Education Examples might include: Conferences; Distance learning; and Computer-based educational experiences. It would not include formal classes or seminars for long-term trainees.						
Technical Assistance Examples might include: Conducting needs assessments with State programs; policy development; grant writing assistance; identifying best-practices; and leading collaborative groups. It would not include conducting needs assessments of consumers of the training program services.						
Product Development Examples might include: Collaborative development of journal articles and training or informational videos.						
Research Examples might include: Collaborative submission of research grants, research teams that include Title V or other MCH-program staff and the training program's faculty.						
Total						

[1]State Title V programs include State Block Grant funded or supported activities.
[2]Other maternal and child health-related programs (both MCHB-funded and funded from other sources) include, but are not limited to:

- State Health Department
- State Adolescent Health
- Social Service Agency
- Medicaid Agency
- Education
- Juvenile Justice
- Early Intervention
- Home Visiting
- Professional Organizations/Associations
- Family and/or Consumer Group
- Foundations
- Clinical Program/Hospitals
- Local and state division of mental health
- Developmental disability agencies
- Other programs working with maternal and child health

Training 09 PERFORMANCE MEASURE **Goal: Long-term Trainees** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of long-term trainees who, at 2, 5 and 10 years post training, work in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families, etc.).
GOAL	To increase the percent of long-term trainees who, upon completing their training, work in an interdisciplinary manner to serve the MCH population.
MEASURE	The percent of long-term trainees who, at 2, 5 and 10 years post training work in an interdisciplinary manner to serve the MCH population.
DEFINITION	**Numerator:** The number of long-term trainees indicating that they continue to work in an interdisciplinary manner serving the MCH population. **Denominator:** The total number of long-term trainees responding to the survey **Units:** 100 **Text:** Percent In addition, data on the total number of the long-term trainees and the number of non-respondents for each year will be collected. Long-term trainees are defined as those who have completed a long-term (300+ hours) MCH Training program, including those who received MCH funds and those who did not.
BENCHMARK DATA SOURCES	Related to Healthy People 2020 Objectives: ECBP-12: Increase the inclusion of core clinical preventive and population health content in M.D.-granting medical schools ECBP-13: Increase the inclusion of core clinical preventive and population health content in D.O.-granting medical schools ECBP-14: Increase the inclusion of core clinical preventive and population health content in undergraduate nursing ECBP-15: Increase the inclusion of core clinical preventive and population health content in nurse practitioner training ECBP-16: Increase the inclusion of core clinical preventive and population health content in physician assistant training PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs and schools of nursing (with a public health or community health component) that integrate Core Competencies

	for Public Health Professionals into curricula MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems
GRANTEE DATA SOURCES	The trainee follow-up survey is used to collect these data.
SIGNIFICANCE	Leadership education is a complex interdisciplinary field that must meet the needs of MCH populations. This measure addresses one of a training program's core values and its unique role to prepare professionals for comprehensive systems of care. By providing interdisciplinary coordinated care, training programs help to ensure that all MCH populations receive the most comprehensive care that takes into account the complete and unique needs of the individuals and their families.

DATA COLLECTION FORM FOR DETAIL SHEET PM #Training 09 - Interdisciplinary Practice

A. 2 YEAR FOLLOW-UP

Numerator: The number of long-term trainees who work in an interdisciplinary manner **2 years** following completion of an MCHB-funded training program. _____

Denominator: The total number of long-term trainees, **2 years** following completion of an MCHB-funded training program, responding to the survey. _____

The total number of program completers lost to follow-up _____

Percent of long-term trainees (**2 years** post program completion) that work in an interdisciplinary manner, demonstrating **at least one** of the following interdisciplinary skills: _____%

- **Sought input** or information from other professions or disciplines to address a need in your work _____%
- **Provided input** or information to other professions or disciplines. _____%
- **Developed a shared vision**, roles and responsibilities within an interdisciplinary group. _____%
- **Utilized that information** to develop a coordinated, prioritized plan across disciplines to address a need in your work _____%
- **Established decision-making** procedures in an interdisciplinary group. _____%
- **Collaborated** with various disciplines across agencies/entities? _____%
- **Advanced policies & programs** that promote collaboration with other disciplines or professions _____%

B. 5 YEAR FOLLOW-UP

Numerator: The number of long-term trainees who work in an interdisciplinary manner **5 years** following completion of an MCHB-funded training program. _____

Denominator: The total number of long-term trainees, **5 years** following completion of an MCHB-funded training program, responding to the survey. _____

The total number of program completers lost to follow-up _____

Percent of long-term trainees (**5 years** post program completion) that work in an interdisciplinary manner, demonstrating **at least one** of the following interdisciplinary skills: _____%

- **Sought input** or information from other professions or disciplines to address a need in your work _____%
- **Provided input** or information to other professions or disciplines. _____%
- **Developed a shared vision**, roles and responsibilities within an interdisciplinary group. _____%
- **Utilized that information** to develop a coordinated, prioritized plan across disciplines to address a need in your work _____%

Established decision-making procedures in an interdisciplinary group. _____%

Collaborated with various disciplines across agencies/entities? _____%

Advanced policies & programs that promote collaboration with other disciplines or professions _____%

C**. 10 YEAR FOLLOW-UP**

Numerator: The number of long-term trainees who work in an interdisciplinary manner **10 years** following completion of an MCHB-funded training program. _____

Denominator: The total number of long-term trainees, **10 years** following completion of an MCHB-funded training program, responding to the survey. _____

The total number of program completers lost to follow-up _____

Percent of long-term trainees (**10 years** post program completion) that work in an interdisciplinary manner, demonstrating **at least one** of the following interdisciplinary skills: _____%

Sought input or information from other professions or disciplines to address a need in your work _____%

Provided input or information to other professions or disciplines. _____%

Developed a shared vision, roles and responsibilities within an interdisciplinary group. _____%

Utilized that information to develop a coordinated, prioritized plan across disciplines to address a need in your work _____%

Established decision-making procedures in an interdisciplinary group. _____%

Collaborated with various disciplines across agencies/entities? _____%

Advanced policies & programs that promote collaboration with other disciplines or professions _____%

Training 10 PERFORMANCE MEASURE **Goal: Diverse Adolescent Involvement** **Level: Grantee** **Domain: MCH Workforce Development**	The degree to which the LEAH program incorporates adolescents and parents from diverse ethnic and cultural backgrounds as advisors and participants in program activities.
GOAL	To increase appropriate involvement of adolescents and parents as consumers of LEAH program activities.
MEASURE	The degree to which adolescents and parents

	are incorporated as consumers of LEAH program activities.
DEFINITION	Attached is a checklist of 4 elements that document adolescent and parent participation. Respondents will note the presence or absence of this participation on a scale of 0-1 for a total possible score of 4.
BENCHMARK DATA SOURCES	Related to Objective HC/HIT-2: Increase the proportion of persons who report that their health care providers have satisfactory communication skills.
GRANTEE DATA SOURCES	Grantees report using a data collection form. These data may be collected with the LEAH self-assessment activities. Participation should be defined to permit assessment of youth and young adult involvement.
SIGNIFICANCE	Over the last decade, policy makers and program administrators have emphasized the central role of consumer of health services as advisors and participants in program activities. Satisfaction with health care is related to satisfaction with the quality of the communication with health providers. In accordance with this philosophy, LEAH facilitates such partnerships and believes that consumers (adolescents and parents) from diverse backgrounds have important roles in the training of future leaders in adolescent health care delivery systems.

DATA COLLECTION FORM FOR DETAIL SHEET PM #Training 10
Indicate the degree to which your training program has the active involvement of adolescents and parents in your program and planning activities using the following values:

0 = No 1 = Yes

If your program does collaborate, provide the total number of activities for the element.

Element	0	1	Total # of Activities
Adolescents from diverse ethnic backgrounds and cultures participate in an advisory capacity.			
Parents of adolescents from diverse ethnic backgrounds and cultures participate in an advisory capacity.			
Adolescents from diverse ethnic backgrounds and cultures participate in the planning, implementation and evaluation of program activities related to adolescents as consumers			
Parents of adolescents from diverse ethnic backgrounds and cultures participate in the planning, implementation and evaluation of program activities related to parents as consumers			

Total Score (possible 0-4 score) _____

Training 11 PERFORMANCE MEASURE	
Goal: Graduate Program Enrollment **Level: Grantee** **Domain: MCH Workforce Development**	The percent of pipeline graduates that enter graduate programs preparing them to work with the MCH population.
GOAL	To increase the number of pipeline graduates that enter graduate programs preparing them to work with the MCH population.
MEASURE	The percent of pipeline graduates that enter graduate programs preparing them to work with the MCH population.
DEFINITION	**Numerator:** Total number of MCH Pipeline graduates enrolled in a graduate school program preparing them to work with the MCH population, 5 years after completing the MCH Pipeline program. Graduate programs preparing students to work with the MCH population include: pediatric medicine, public health, pediatric nutrition, public health social work, pediatric nursing, pediatric dentistry, psychology, health education, health administration, pediatric occupational/physical therapy, or speech language pathology. **Denominator:** Total number of MCH Pipeline graduates who completed the MCH pipeline program 5 years previously.
BENCHMARK DATA SOURCES	Related to Healthy People 2020 Objectives: ECBP-12: Increase the inclusion of core clinical preventive and population health content in M.D.-granting medical schools ECBP-13: Increase the inclusion of core clinical preventive and population health content in D.O.-granting medical schools ECBP-14: Increase the inclusion of core clinical preventive and population health content in undergraduate nursing ECBP-15: Increase the inclusion of core clinical preventive and population health content in nurse practitioner training ECBP-16: Increase the inclusion of core clinical preventive and population health content in physician assistant training PHI-1: Increase the proportion of Federal,

	Tribal, State, and local public health agencies that incorporate Core Competencies for Public Health Professionals into job descriptions and performance evaluations
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantees.
SIGNIFICANCE	MCHB training programs assist in developing a public health workforce that addresses MCH concerns and fosters field leadership in the MCH arena.

DATA COLLECTION FORM FOR DETAIL SHEET # Training 11

2 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

A. The total number of graduates, 2 years following completion of program _____

B. The total number of graduates lost to follow-up _____

C. The total number of respondents (A-B) = denominator _____

D. Number of respondents that are enrolled in graduate Programs preparing them work with the MCH population** _____

E. Percent of respondents that are enrolled in graduate Programs preparing them work with the MCH population _____

5 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

A. The total number of graduates, 5 years following completion of program _____

B. The total number of graduates lost to follow-up _____

C. The total number of respondents (A-B) = denominator _____

D. Number of respondents that are enrolled in graduate Programs preparing them work with the MCH population** _____

E. Percent of respondents that are enrolled in graduate Programs preparing them work with the MCH population _____

**Graduate programs preparing graduate students to work in the MCH population include:
Pediatric medicine, public health, pediatric nutrition, public health social work, pediatric nursing, pediatric dentistry, psychology, health education, health administration, pediatric occupational/physical therapy, speech language pathology.

Training 12 PERFORMANCE MEASURE **Goal: Long-term trainees working with MCH populations** **Level: Grantee** **Domain: MCH Workforce Development**	The percentage of long-term trainees who are engaged in work focused on MCH populations after completing their MCH Training Program.
GOAL	To increase the percent of long-term trainees engaged in work focused on MCH populations two and five years after completing their MCH Training Program.
MEASURE	The percentage of long-term trainees who are engaged in work focused on MCH populations after completing their MCH Training Program.
DEFINITION	**Numerator:** Number of long-term trainees reporting they are engaged in work focused on MCH populations after completing their MCH Training Program. **Denominator:** The total number of trainees responding to the survey **Units:** 100 **Text:** Percent Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) MCH Training Program, including those who received MCH funds and those who did not. Cohort is defined as those who have completed an MCHB-funded training program 2 years and 5 years prior to the reporting period. MCH Populations: Includes all of the Nation's women, infants, children, adolescents, young adults and their families, including and children with special health care needs.
BENCHMARK DATA SOURCES	Related to ECBP-10 Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services… Related to ECBP-11(Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.

	Related to PHI-1Increase the proportion of Federal, Tribal, State, and local public health agencies that incorporate Core Competencies for Public Health Professionals into job descriptions and performance
GRANTEE DATA SOURCES	A revised trainee follow-up survey that incorporates the new form for collecting data on the involvement of those completing an MCH training program in work related to MCH populations will be used to collect these data. Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Pillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med*2008;6:397-405. DOI: 10.1370/afm.885. Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA.*2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154).
SIGNIFICANCE	HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care.

DATA COLLECTION FORM FOR DETAIL SHEET PM #Training 12

Individuals completing a long-term training program who report working with the **maternal and child health population** (i.e., women, infants, children, adolescents, young adults and their families, including children with special health care needs) at 2 years and at 5 years after completing their training program.

NOTE: If the individual works with more than one of these groups only count them once.

A. The total number of long-term trainees, **2 years** following program completion _____

B. The total number of long-term trainees lost to follow-up (**2 years** following program completion) _____

C. The total number of respondents (A-B) = denominator _____

D. Number of respondents **2 years** following completion of program who report working with an MCH population _____

E. Percent of respondents **2 years** following completion of program who report working with an MCH population _____

F. The total number of long-term trainees, **5 years** following program completion _____

G. The total number of long-term trainees lost to follow-up (**5 years** following program completion), _____

H. The total number of respondents (F-G) = denominator _____

I. Number of respondents **5 years** following completion of program who report working with an MCH population _____

J. Percent of respondents **5 years** following completion of program who report working with an MCH population _____

Training 13 PERFORMANCE MEASURE **Goal: Policy Development** **Level: Grantee** **Domain: MCH Workforce Development**	The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
GOAL	To increase the number of MCH long-term training programs that actively promote the transfer and utilization of MCH knowledge and research to the policy arena through the work of faculty, trainees, alumni, and collaboration with Title V.
MEASURE	The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
DEFINITION	Attached is a list of six elements that demonstrate policy engagement. Please check yes or no to indicate which the elements have been implemented. Please keep the completed checklist attached. Policy development, implementation and evaluation in the context of MCH training programs relates to the process of translating research to policy and training for leadership in the core public health function of policy development. Actively – mutual commitment to policy-related projects or objectives within the past 12 months.
BENCHMARK DATA SOURCES	Related to PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula.
GRANTEE DATA SOURCES	• Attached data collection form to be completed by grantee. • Data will be collected from competitive and continuation applications as part of the grant application process and annual reports. The elements of training program engagement in policy development, implementation, and evaluation need to be operationally defined with progress noted on the attached list with an example described more fully in the narrative application.

SIGNIFICANCE

Policy development is one of the three core functions of public health as defined in 1988 by the Institute of Medicine in The Future of Public Health (National Academy Press, Washington DC). In this landmark report by the IOM, the committee recommends that "every public health agency exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision-making about public health and by leading in developing public health policy." Academic institutions such as schools of public health and research universities have the dual responsibility to develop knowledge and to produce well-trained professional practitioners. This national performance measure relates directly to Goal 4 of the Division of MCH Workforce Development Strategic Plan to "generate and translate new knowledge for the MCH field in order to advance science-based practice, innovation, and quality improvement in MCH training, policies and programs.".

DATA COLLECTION FORM FOR DETAIL SHEET PM #Training 13 - Policy Development

Using a response of Yes (1) or No (0), indicate whether your training program has addressed the following policy training and policy participation elements.

CATEGORY #1: Training on Policy and Advocacy

Element	No 0	Yes 1
1. Your MCHB-funded Training Program provides didactic opportunities for training on policy development and advocacy to increase understanding of how the policy process works at the federal, state and/or local levels.		
2. Your MCHB-funded Training Program provides an opportunity for application of policy and advocacy knowledge through one or more of the following educational experiences **If Yes, check all that apply:** ☐ Write a policy brief about an emerging local MCH public health issue ☐ Attend a meeting of a local MCH stakeholder group, provide a written summary of their approach ☐ Attend a professional association meeting and actively participate on a committee ☐ Educate Policymakers ☐ Provide written and/or oral testimony to the state legislature ☐ Write an non-scientific article on an MCH topic for a lay audience ☐ Observe a legislative hearing on CSPAN, or if possible, attend a legislative hearing on an MCH topic ☐ Track a bill over the Internet over the course of a legislative session ☐ Interview an agency or organization-based MCH policy maker, administrator, or advocate and prepare written and/or oral mock testimony from the perspective of the agency/association interviewed ☐ Other, please describe _____		
3. A pre/post assessment is in place to measure increased policy knowledge and skills of trainees If Yes, report: a. % of current trainees reporting increased policy knowledge _____ b. % of current trainees reporting increased policy skills _____		

CATEGORY #2: Participation in Policy Change and Translation of Research into Policy

Element	No 0	Yes 1
4. Trainees, faculty and/or staff contribute to the development of guidelines, regulation, legislation **or** other public policy at the local, state, and/or national level. If yes, indicate the policy arenas to which they have contributed: ☐ Local ☐ State ☐ National		
5. Trainees, faculty and/or staff participate in local, state and/or national MCH advocacy networks and initiatives If yes, indicate the policy arenas that have contributed to: ☐ Local ☐ State ☐ National		
6. Trainees, faculty and/or staff participate in disseminating and communicating research findings (both original and non-original) directly to public health agency leaders and/or policy officials. If yes, indicate the policy arenas that have contributed to: ☐ Local ☐ State ☐ National		

Training 14 PERFORMANCE MEASURE **Goal: Medium-Term Trainees Skill and Knowledge** **Level: Grantee** **Domain: MCH Workforce Development**	The percentage of Level I medium term trainees who report an increase in knowledge and the percentage of Level II medium term trainees who report an increase in knowledge or skills related to MCH core competencies .
GOAL	To increase the percentage of medium term trainees (MTT) who report increased knowledge or skills related to MCH core competencies.
MEASURE	The percentage of Level I medium term trainees who report an increase in knowledge and the percentage of Level II medium term trainees who report an increase in knowledge or skills related to MCH core competencies.
DEFINITION	**Numerator:** The number of Level I medium term trainees who report an increase in knowledge and Level II medium term trainees who report an increase in knowledge or skills related to MCH core competencies. **Denominator:** The total number of medium term trainees responding to the survey. Medium Term trainees: Level I MTT complete 40-149 hours of training. Level II MTT complete 150–299 hours of training.
BENCHMARK DATA SOURCES	MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems. ECBP-19: Increase the proportion of academic institutions with health professions education programs whose prevention curricula include interprofessional educational experiences. ECBP-12.2: Increase the inclusion of cultural diversity content in M.D.-granting medical schools. ECBP-13.2: Increase the inclusion of cultural diversity content in D.O.-granting medical schools. ECBP-15.2: Increase the inclusion of cultural diversity content in nurse practitioner training. ECBP-17.2: Increase the inclusion of cultural diversity content in Doctor of Pharmacy (PharmD) granting colleges and schools of pharmacy.
GRANTEE DATA SOURCES	End of training survey is used to collect these

	data.
SIGNIFICANCE	Medium Term trainees comprise a significant proportion of training efforts. These trainees impact the provision of care to CYSHCN nationally. The impact of this training must be measured and evaluated.

DATA COLLECTION FORM FOR DETAIL SHEET PM #Training 14

Level I Medium Term Trainees - Knowledge

A. The total number of Level I Medium-Term Trainees (40-149 hours) _____
B. The total number of Level I MTT lost to follow-up _____
C. The total number of respondents (A-B) _____
D. Number of respondents reporting increased knowledge _____
E. Percentage of respondents reporting increased knowledge _____

Level II Medium Term Trainees – Knowledge:

A. The total number of Level II Medium-Term Trainees (150-299 hours) _____
B. The total number of Level II MTT lost to follow-up _____
C. The total number of respondents (A-B) _____
D. Number of respondents reporting increased knowledge _____
E. Percentage of respondents reporting increased knowledge _____

Level II Medium Term Trainees - Skills :

A. The total number of Level II Medium-Term Trainees (150-299 hours) _____
B. The total number of Level II MTT lost to follow-up _____
C. The total number of respondents (A-B) _____
D. Number of respondents reporting increased skills _____
E. Percentage of respondents reporting increased skills _____

DIVISION OF CHILD ADOLESCENT, AND FAMILY HEALTH
Emergency Medical Services for Children Program
PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

Performance Measure	New/Revised Measure	Prior PM Number (if applicable)	Topic
EMSC 01	New	N/A	Submission of NEMSIS compliant version 3.x data to the State EMS Office for submission to NEMSIS Technical Assistance Center
EMSC 02	New	N/A	Pediatric Emergency Care Coordination
EMSC 03	New	N/A	Use of pediatric-specific equipment
EMSC 04	Unchanged	74	Pediatric medical emergencies
EMSC 05	Unchanged	75	Pediatric traumatic emergencies
EMSC 06	Unchanged	76	Written inter-facility transfer guidelines that contain all the components as per the implementation manual
EMSC 07	Unchanged	77	Written inter-facility transfer agreements that covers pediatric patients.
EMSC 08	Unchanged	79	Established permanence of EMSC
EMSC 09	Unchanged	80	Established permanence of EMSC by integrating EMSC priorities into statutes/regulations.

EMSC 01 PERFORMANCE MEASURE **Goal: Submission of NEMSIS compliant version 3.x data** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The degree to which EMS agencies submit NEMSIS compliant version 3.x data to the State EMS Office for submission to NEMSIS Technical Assistance Center (TAC).
GOAL	By 2018, baseline data will be available to assess the number of EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X compliant patient care data to the State Emergency Medical Services Office for all 911 initiated EMS activations. By 2021, 90% of licensed EMS agencies in the state/territory submit National Emergency Medical Services Information System (NEMSIS) version 3.X compliant patient care data to the State Emergency Medical Services Office for all 911 initiated EMS activations.
MEASURE	The degree to which EMS agencies submit NEMSIS compliant version 3.x data to the State EMS Office for submission to NEMSIS Technical Assistance Center (TAC).
DEFINITION	**Numerator:** The number of EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X compliant patient care data to the State Emergency Medical Services Office. **Denominator:** Total number of EMS agencies in the state/territory as reported by the State EMS Office. **Units:** 100 **Text:** Percent **EMS:** Emergency Medical Services **EMS Agency**: A prehospital provider agency. An EMS agency is defined as an organization staffed with personnel who are actively rendering medical care in response to a 911 or similar emergency call. Data will be gathered

	from State EMS Offices for both transporting and non-transporting agencies (excludes air- and water-only EMS services). **NEMSIS**: National EMS Information System. NEMSIS is the national repository that is used to store EMS data from every state in the nation. **NEMSIS Version 3.X compliant patient care data**: A national set of standardized data elements collected by EMS agencies. **NEMSIS Technical Assistance Center (TAC)**: The NEMSIS TAC is the resource center for the NEMSIS project. The NEMSIS TAC provides assistance states, territories, and local EMS agencies, creates reference documents, maintains the NEMSIS database and XML schemas, and creates compliance policies. **NHTSA** – National Highway Traffic Safety Administration
HRSA STRATEGIC OBJECTIVE	Improve Access to Quality Health Care and Services by strengthening health systems to support the delivery of quality health services. Improve Health Equity by monitoring, identifying, and advancing evidence-based and promising practices to achieve health equity.
DATA SOURCES AND ISSUES	State EMS Offices
SIGNIFICANCE	Access to quality data and effective data management play an important role in improving the performance of an organization's health care systems. Collecting, analyzing, interpreting, and acting on data for specific performance measures allows health care professionals to identify where systems are falling short, to make corrective adjustments, and to track outcomes. [1] However, uniform

[1] Health Resources and Services Administration, "Quality Improvement Methodology, Managing Data for Performance Improvement. http://www.hrsa.gov/quality/toolbox/methodology/performanceimprovement/

data collection is needed to consistently evaluate systems and develop Quality Improvement programs. The National EMS Information System, (NEMSIS) operated by the National Highway Traffic Safety Administration, provides a basic platform for states and territories to collect and report patient care data in a uniform manner. NEMSIS enables both state and national EMS systems to evaluate their current prehospital delivery system and in the next few years, NEMSIS will help states and territories evaluate patient outcomes. As a first step toward Quality Improvement in pediatric emergency medical and trauma care, the EMSC Program seeks to first understand the proportion of EMS agencies reporting to the state EMS office NEMSIS version 3.X compliant data, then use that information to improve data collection and promote its full use at the EMS agency level.

While most localities collect and most states report NEMSIS version 2.X compliant data currently, NEMSIS version 3.x is available today and in use in several states. Version 3 includes an expanded data set, which significantly increases the information available on critically ill or injured children. NHTSA is encouraging states and localities to upgrade to version 3.X compliant software and submit version 3.X data by January 1, 2018.

DATA COLLECTION FORM FOR DETAIL SHEET PM #EMSC 01

The percentage of EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X compliant patient care data to the State Emergency Medical Services Office for all 9-1-1 initiated EMS activations.

Numerator: The number of licensed EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X compliant patient care data to the State Emergency Medical Services Office for all 9-1-1 initiated EMS activations
Denominator: Total number of licensed EMS agencies in the state/territory actively responding to 9-1-1 requests for assistance.
Percent:

State EMS Offices will be asked to select which of six (6) statements best describes their current status. The measure will be determined on a scale of 0-5. The following table shows the scoring rubric for responses. Achievement for grantees will be reached when the State EMS Office submits NEMSIS version 3.X compliant patient care data to the NEMSIS TAC with at least 90% of the currently active, licensed EMS agencies reporting to the State EMS Office. This is represented by a score of "5".

Which statement best describes your current status?	Current Progress
Our State EMS Office does not submit patient care data to the NEMSIS Technical Assistance Center (TAC)	0
Our State EMS Office intends to submit NEMSIS version 3.X compliant patient care data to NEMSIS TAC by or before 2020.	1
Our State EMS Office submits NEMSIS version 3.X compliant patient care data to NEMSIS TAC with at least 10% of licensed EMS agencies reporting.	2
Our State EMS Office submits NEMSIS version 3.X compliant patient care data to NEMSIS TAC with at least 25% of the licensed EMS agencies reporting.	3
Our State EMS Office submits NEMSIS version 3.X compliant patient care data to NEMSIS TAC with at least 50% of the licensed EMS agencies reporting.	4
Our State EMS Office submits NEMSIS version 3.X compliant patient care data to NEMSIS TAC with at least 90% of the licensed EMS agencies reporting.	5

Proposed Survey Questions:

As part of the HRSA's quest to improve the quality of healthcare, the EMSC Program is interested to hear about current efforts to collect NEMSIS version 3.X compliant patient care data from licensed EMS agencies in the state/territory. The EMSC Program aims to first understand the proportion of EMS agencies that are submitting NEMSIS version 3.X compliant patient care data to the state EMS office. The NEMSIS Technical Assistance Center will only collect version 3.X compliant data beginning on January 1, 2017.

Which one of the following statements best describes your current status toward submitting NEMSIS version 3.X compliant patient care data to the NEMSIS TAC from currently active licensed EMS agencies in the state/territory**?** (Choose one)

☐ Our State EMS Office does not submit patient care data to the NEMSIS Technical Assistance Center (TAC)

☐ Our State EMS Office intends to submit patient care data to the NEMSIS Technical Assistance Center (TAC) by or before 2020.

☐ Our State EMS Office submits NEMSIS version 3.X compliant patient care data to the NEMSIS Technical Assistance Center (TAC) with at least 10% of licensed EMS agencies reporting.

☐ Our State EMS Office submits NEMSIS version 3.X compliant patient care data to the NEMSIS Technical Assistance Center (TAC) with at least 25% of licensed EMS agencies reporting.

☐ Our State EMS Office submits NEMSIS version 3.X compliant patient care data to the NEMSIS Technical Assistance Center (TAC) with at least 50% of licensed EMS agencies reporting.

☐ Our State EMS Office submits NEMSIS version 3.X compliant patient care data to the NEMSIS Technical Assistance Center (TAC) with at least 90% of licensed EMS agencies reporting.

EMSC 02 PERFORMANCE MEASURE **Goal: Pediatric Emergency Care Coordination** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care.
GOAL	By 2020, 30% of EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care. By 2023, 60% of EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care. By 2026, 90% of EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care.
MEASURE	The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care.
DEFINITION	**Numerator:** The number of EMS agencies in the state/territory that score a '3' on a 0-3 scale. **Denominator:** Total number of EMS agencies in the state/territory that provided data. **Units:** 100 **Text:** Percent Recommended Roles: Job related activities that the designated individual who coordinates pediatric emergency care might oversee at an EMS agency are: • Ensure that the pediatric perspective is included in the development of EMS protocols • Ensure that fellow EMS providers follow pediatric clinical practice guidelines • Promote pediatric continuing education opportunities • Oversee pediatric process improvement • Ensure the availability of pediatric medications, equipment, and supplies • Promote agency participation in pediatric prevention programs • Promote agency participation in pediatric research efforts • Liaises with the emergency department pediatric emergency care coordinator **EMS:** Emergency Medical Services

	EMS Agency: An EMS agency is defined as an organization staffed with personnel who render medical care in response to a 911 or similar emergency call. Data will be gathered from both transporting and non-transporting agencies. **IOM:** Institute of Medicine
HRSA STRATEGIC OBJECTIVE	Strengthen the Health Workforce
DATA SOURCE(S) AND ISSUES	Survey of EMS agencies
SIGNIFICANCE	The Institute of Medicine (IOM) report "Emergency Care for Children: Growing Pains" (2007) recommends that EMS agencies and emergency departments (EDs) appoint a pediatric emergency care coordinator to provide pediatric leadership for the organization. . .This individual, need not be dedicated solely to this role and could be personnel already in place with a special interest in children who assumes this role as part of their existing duties. Gausche-Hill et al in a national study of EDs found that the presence of a physician or nurse pediatric emergency care coordinator was associated with an ED being more prepared to care for children. EDs with a coordinator were more likely to report having important policies in place and a quality improvement plan that addressed the needs of children than EDs that reported not having a coordinator. The IOM report further states that pediatric coordinators are necessary to advocate for improved competencies and the availability of resources for pediatric patients. The presence of an individual who coordinates pediatric emergency care at EMS agencies may result in ensuring that the agency and its providers are more prepared to care for ill and injured children.

DATA COLLECTION FORM FOR DETAIL SHEET PM #EMSC 02

The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care.

Numerator: The number of EMS agencies in the state/territory that score a '3' on a 0-3 scale.	
Denominator: Total number of EMS agencies in the state/territory that provided data.	
Percent:	

EMS agencies will be asked to select which of four statements best describes their agency. The measure will be determined on a scale of 0-3. The following table shows the scoring rubric for responses. Achievement for grantees will be reached when at least 50% of the EMS agencies in the state/territory report a '3' on the scale below.

Which statement best defines your agency?	Scale
Our EMS agency does NOT have a designated INDIVIDUAL who coordinates pediatric emergency care at this time	0
Our EMS agency does NOT CURRENTLY have a designated INDIVIDUAL who coordinates pediatric emergency care but we would be INTERESTED IN ADDING this role	1
Our EMS agency does NOT CURRENTLY have a designated INDIVIDUAL who coordinates pediatric emergency care but we HAVE A PLAN TO ADD this role within the next year	2
Our EMS agency HAS a designated INDIVIDUAL who coordinates pediatric emergency care	3

Proposed Survey Questions:

Now we are interested in hearing about how pediatric emergency care is coordinated at your EMS agency. This is an emerging issue within emergency care and we want to gather information on what is happening across the country within EMS agencies.

One way that an agency can coordinate pediatric emergency care is by DESIGNATING AN INDIVIDUAL who is responsible for pediatric-specific activities that could include:

- Ensure that the pediatric perspective is included in the development of EMS protocols
- Ensur that fellow providers follow pediatric clinical practice guidelines
- Promot pediatric continuing education opportunities
- Oversee pediatric process improvement
- Ensur the availability of pediatric medications, equipment, and supplies
- Promot agency participation in pediatric prevention programs
- Promote agency participation in pediatric research efforts

The DESIGNATED INDIVIDUAL who coordinates pediatric emergency care need not be dedicated solely to this role; it can be an individual already in place who assumes this role as part of their existing duties.

Which one of the following statements best describes your EMS agency? (Choose one)

- ☐ Our EMS agency does ***NOT*** have a designated ***INDIVIDUAL*** who coordinates pediatric emergency care at this time
- ☐ Our EMS agency does ***NOT CURRENTLY*** have a designated ***INDIVIDUAL*** who coordinates pediatric emergency care but we would be ***INTERESTED IN ADDING*** this role
- ☐ Our EMS agency does ***NOT CURRENTLY*** have a designated ***INDIVIDUAL*** who coordinates pediatric emergency care but we ***HAVE A PLAN TO ADD*** this role within the next year
- ☐ Our EMS agency ***HAS*** a designated ***INDIVIDUAL*** who coordinates pediatric emergency care

You indicated that you have a designated individual who coordinates pediatric emergency care at your EMS agency.

Does this designated individual…

(Check Yes or No for each of the following questions)

Ensure that the pediatric perspective is included in the development of EMS protocols

- ☐ Yes
- ☐ No

Ensure that fellow providers follow pediatric clinical practice guidelines

- ☐ Yes
- ☐ No

Promote pediatric continuing education opportunities

- ☐ Yes
- ☐ No

Oversee pediatric process improvement

- ☐ Yes
- ☐ No

Ensure the availability of pediatric medications, equipment, and supplies

- ☐ Yes
- ☐ No

Promote agency participation in pediatric prevention programs

- ☐ Yes
- ☐ No

Promote agency participation in pediatric research efforts

- ☐ Yes
- ☐ No

Other

- ☐ Yes
- ☐ No

You marked 'other' to the previous question. Please describe the 'other' activity(s) performed by the designated individual who coordinates pediatric emergency care at your agency. _____

If you have any additional thoughts about pediatric emergency care coordination, please share them here:

EMSC 03 PERFORMANCE MEASURE **Goal : Use of pediatric-specific equipment** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percentage of EMS agencies in the state/territory that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
GOAL	By 2020, 30% of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of '8' or more on a 0-12 scale. See data collection form below for more details on the scale used in this measure. By 2023: 60% of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of '8' or more on a 0-12 scale. See data collection form below for more details on the scale used in this measure. By 2026: 90% of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of '8' or more on a 0-12 scale. See data collection form below for more details on the scale used in this measure.
MEASURE	The percentage of EMS agencies in the state/territory that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
DEFINITION	**Numerator:** The number of EMS agencies in the state/territory that score an '8' or more on a 0-12 scale **Denominator:** Total number of EMS agencies in the state/territory that provided data. **Units:** 100 **Text:** Percent **EMS:** Emergency Medical Services **EMS Agency**: An EMS agency is defined as an organization staffed with personnel who render medical care in response to a 911 or similar emergency call. Data will be gathered from both transporting and non-transporting agencies. IOM: Institute of Medicine **EMS Providers:** EMS providers are defined as people/persons who are certified or licensed to provide emergency medical services during a 911 or similar emergency call. There are four EMS personnel licensure levels: Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced

	Emergency Medical Technician (AEMT), and Paramedic. Reference the National Highway Traffic Safety Administration (NHTSA) National EMS Scope of Practice Model http://www.ems.gov/education/EMSScope.pdf
HRSA STRATEGIC OBJECTIVE	Goal I: Improve Access to Quality Health Care and Services (by improving quality) or Goal II: Strengthen the Health Workforce
DATA SOURCE(S) AND ISSUES	Survey of EMS agencies
SIGNIFICANCE	The Institute of Medicine (IOM) report "Emergency Care for Children: Growing Pains" reports that because EMS providers rarely treat seriously ill or injured pediatric patients, providers may be unable to maintain the necessary skill level to care for these patients. For example, Lammers et al reported that paramedics manage an adult respiratory patient once every 20 days compared to once every 625 days for teens, 958 days for children and once every 1,087 days for infants. As a result, skills needed to care for pediatric patients may deteriorate. Another study by Su et al found that EMS provider knowledge rose sharply after a pediatric resuscitation course, but when providers were retested six months later; their knowledge was back to baseline. While continuing education such as the Pediatric Advance Life Support (PALS) and Pediatric Education for Prehospital Professionals (PEPP) courses are vitally important for maintaining skills and are considered an effective remedy for skill atrophy, these courses are typically only required every two years. More frequent practice of skills using different methods of skill ascertainment are necessary for EMS providers to ensure their readiness to care for pediatric patients when faced with these infrequent encounters. Demonstrating skills using EMS equipment is best done in the field on actual patients but in the case of pediatric patients this can be difficult given how infrequently EMS providers see seriously ill or injured children. Other methods for assessing skills include simulation, case scenarios and skill stations. In the absence of pediatric patient encounters in the field. There is not definitive evidence that shows that one method is more effective than another for demonstrating clinical skills. But, Miller's Model of Clinical Competence posits via the skills complexity triangle that performance assessment can be demonstrated by a combination of task training, integrated skills training, and integrated team performance. In the EMS environment this can be translated to task training at skill stations, integrated skills training during case scenarios, and integrated team performance while treating patients in the field.

DATA COLLECTION FORM FOR DETAIL SHEET PM #EMSC 03

The percentage of EMS agencies in the state/territory that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.

Numerator: The number of EMS agencies in the state/territory that score an '8' or more on a 0-12 scale.	
Denominator: Total number of EMS agencies in the state/territory that provided data.	
Percent:	

EMS agencies will be asked to select the frequency of each of three methods used to evaluate EMS providers' use of pediatric-specific equipment. The measure will be determined on a scale of 0 – 12. The following table shows the scoring rubric for responses. Achievement for the grantees will be reached when at least 90% of the EMS agencies in a state/territory report a combined score of '8' or higher from each of the three methods.

	Two or more times per year	**At least once per year**	**At least once every two years**	**Less frequency than once every two years**
How often are your providers required to demonstrate skills via a SKILL STATION?	**4**	**2**	**1**	**0**
How often are your providers required to demonstrate skills via a CASE SCENARIO?	**4**	**2**	**1**	**0**
How often are your providers required to demonstrate skills via a FIELD ENCOUNTER?	**4**	**2**	**1**	**0**

Proposed Survey Questions:

In the next set of questions we are asking about how frequently providers at your agency are required to physically demonstrate the correct use of pediatric-specific equipment.

There may be multiple processes that EMS agencies use to evaluate their EMS providers' skills using pediatric-specific equipment. We are interested in the following three processes:

- At a skill station
- Within a simulated event
- During an actual pediatric patient encounter

At a *SKILL STATION* (not part of a simulated event), does your agency have a process which *REQUIRES* your EMS providers to *PHYSICALLY DEMONSTRATE* the correct use of *PEDIATRIC-SPECIFIC* equipment?

- ☐ Yes
- ☐ No

How often is this process required for your EMS providers? (Choose one)

- ☐ Two or more times a year
- ☐ At least once a year
- ☐ At least once every two years
- ☐ Less frequently than once every two years

Within *A SIMULATED EVENT* (such as a case scenario or a mock incident), does your agency have a process which *REQUIRES* your EMS providers to *PHYSICALLY DEMONSTRATE* the correct use of *PEDIATRIC-SPECIFIC* equipment?

- ☐ Yes
- ☐ No

How often is this process required for your EMS providers? (Choose one)

- ☐ Two or more times a year
- ☐ At least once a year
- ☐ At least once every two years
- ☐ Less frequently than once every two years

During an actual *PEDIATRIC PATIENT ENCOUNTER*, does your agency have a process which *REQUIRES* your EMS providers to be observed by a *FIELD TRAINING OFFICER* or *SUPERVISOR* to ensure the correct use of *PEDIATRIC-SPECIFIC* equipment?

- ☐ Yes
- ☐ No

How often is this process required for your EMS providers? (Choose one)

- ☐ Two or more times a year
- ☐ At least once a year
- ☐ At least once every two years

☐ Less frequently than once every two years

If you have any additional thoughts about skill checking, please share them here:

_____

EMSC 04 PERFORMANCE MEASURE **NO CHANGE FROM PRIOR PM 74**	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
GOAL	By 2017: • 25% of hospitals are recognized as part of a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
MEASURE	The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
DEFINITION	**Numerator:** Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies. **Denominator:** Total number of hospitals with an ED in the State/Territory. **Units:** 100 **Text:** Percent **Standardized system:** A system that recognizes the readiness and capability of a hospital and its staff to triage and provide care appropriately, based upon the severity of illness/injury of the child. The system designates/verifies hospitals as providers of a certain level of emergency care within a specified geographic area (e.g., region). A facility recognition process usually involves a formal assessment of a hospital's capacity to provide pediatric emergency care via site visits and/or a formal application process implemented by a State/Territory or local government body, such as the State EMSC Program, State EMS Office, and/or local hospital/health care provider association. **Hospital:** Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care. Objective 2.3: Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma.
DATA SOURCE(S) AND ISSUES	• This performance measure will require grantees to determine how many hospitals participate in their facility recognition program (if the state has a facility recognition program) for trauma and for

medical.

SIGNIFICANCE

The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional system that recognizes hospitals capable of stabilizing and/or managing pediatric medical emergencies and trauma. A standardized categorization and/or designation process assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency and specialty care.

DATA COLLECTION FORM FOR DETAIL SHEET # EMSC 04

The percent of hospitals with an Emergency Department (ED) that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.

Numerator:	
Denominator:	
Percent	

Numerator: Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
Denominator: Total number of hospitals with an ED in the State/Territory.

Using a scale of 0-5, please rate the degree to which your State/Territory has made towards establishing a recognition system for pediatric medical emergencies.

Element	0	1	2	3	4	5
1. Indicate the degree to which a standardized system for pediatric medical emergencies exists.						

0= No progress has been made towards developing a statewide, territorial, or regional system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies

1= Research has been conducted on the effectiveness of a pediatric medical facility recognition program (i.e., improved pediatric outcomes)
And/or
Developing a pediatric medical facility recognition program has been discussed by the EMSC Advisory Committee and members are working on the issue.

2= Criteria that facilities must meet in order to receive recognition as a pediatric medical facility have been developed.

3= An implementation process/plan for the pediatric medical facility recognition program has been developed.

4= The implementation process/plan for the pediatric medical facility recognition program has been piloted.

5= At least one facility has been formally recognized through the pediatric medical facility recognition program

EMSC 05 PERFORMANCE MEASURE **NO CHANGE FROM PRIOR PM 75**	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
GOAL	By 2017: • 50% of hospitals are recognized as part of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric trauma.
MEASURE	The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
DEFINITION	**Numerator:** Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies. **Denominator:** Total number of hospitals with an ED in the State/Territory. **Units:** 100 **Text:** Percent **Standardized system:** A system that recognizes the readiness and capability of a hospital and its staff to triage and provide care appropriately, based upon the severity of illness/injury of the child. The system designates/verifies hospitals as providers of a certain level of emergency care within a specified geographic area (e.g., region). A facility recognition process usually involves a formal assessment of a hospital's capacity to provide pediatric emergency care via site visits and/or a formal application process implemented by a State/Territory or local government body, such as the State EMSC Program, State EMS Office, and/or local hospital/health care provider association. **Hospital:** Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care. Objective 2.3: Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma.
DATA SOURCE(S) AND ISSUES	• This performance measure will require grantees to determine how many hospitals participate in their facility recognition program (if the state has a facility recognition program) for trauma and for

medical.

SIGNIFICANCE

The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional system that recognizes hospitals capable of stabilizing and/or managing pediatric medical emergencies and trauma. A standardized categorization and/or designation process assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency and specialty care.

DATA COLLECTION FORM FOR DETAIL SHEET # EMSC 05

The percent of hospitals with an Emergency Department (ED) that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.

Numerator:	
Denominator:	
Percent	

Numerator: Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
Denominator: Total number of hospitals with an ED in the State/Territory.

Using a scale of 0-5, please rate the degree to which your State/Territory has made towards establishing a recognition system for pediatric traumatic emergencies.

Element	0	1	2	3	4	5
1. Indicate the degree to which a standardized system for pediatric traumatic emergencies exists.						

0= No progress has been made towards developing a statewide, territorial, or regional system that recognizes hospitals that are able to stabilize and/or manage pediatric trauma emergencies

1= Research has been conducted on the effectiveness of a pediatric trauma facility recognition program (i.e., improved pediatric outcomes)
And/or
Developing a pediatric trauma facility recognition program has been discussed by the EMSC Advisory Committee and members are working on the issue.

2= Criteria that facilities must meet in order to receive recognition as a pediatric trauma facility have been developed.

3= An implementation process/plan for the pediatric trauma facility recognition program has been developed.

4= The implementation process/plan for the pediatric trauma facility recognition program has been piloted.

5= At least one facility has been formally recognized through the pediatric trauma facility recognition program

EMSC 06 PERFORMANCE MEASURE **NO CHANGE FROM PRIOR PM 76**	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that contain all the components as per the implementation manual.
GOAL	By 2021: • 90% of hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include specific components of transfer.
MEASURE	The percentage of hospitals in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer: • Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication). • Process for selecting the appropriate care facility. • Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.). • Process for patient transfer (including obtaining informed consent). • Plan for transfer of patient medical record • Plan for transfer of copy of signed transport consent • Plan for transfer of personal belongings of the patient • Plan for provision of directions and referral institution information to family
DEFINITION	**Numerator:** Number of hospitals with an ED that have written inter-facility transfer guidelines that cover pediatric patients and that include specific components of transfer according to the data collected. **Denominator:** Total number of hospitals with an ED that provided data. **Units:** 100 **Text:** Percent **Pediatric:** Any person 0 to 18 years of age. **Inter-facility transfer guidelines:** Hospital-to-hospital, including out of State/Territory, guidelines that outline procedural and administrative policies for transferring critically ill patients to facilities that provide specialized pediatric care, or pediatric services not available at the referring facility. Inter-facility guidelines do not have to specify transfers of pediatric patients only. A guideline that applies to **all patients or patients of all ages** would suffice, as long as it is not written only for adults. Grantees should consult the EMSC Program representative if they have questions regarding guideline

inclusion of pediatric patients. In addition, hospitals may have one document that comprises both the inter-facility transfer guideline and agreement. This is acceptable as long as the document meets the definitions for pediatric inter-facility transfer guidelines and agreements (i.e., the document contains all components of transfer).

All hospitals in the State/Territory should have guidelines to transfer to a facility capable of providing pediatric services not available at the referring facility. If a facility cannot provide a particular type of care (e.g., burn care), then it also should have transfer guidelines in place. Consult the NRC to ensure that the facility (facilities) providing the highest level of care in the state/territory is capable of definitive care for all pediatric needs. Also, note that being in compliance with EMTALA does not constitute having inter-facility transfer guidelines.

Hospital: Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department (ED). Excludes Military and Indian Health Service hospitals.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care

Objective 2.4: Develop written pediatric inter-facility transfer guidelines for hospitals.

DATA SOURCE(S) AND ISSUES

- Surveys of hospitals with an emergency department.
- Hospital licensure rules and regulations

SIGNIFICANCE

In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and guidelines.

EMSC 07 PERFORMANCE MEASURE **NO CHANGE FROM PRIOR PM 77**	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
GOAL	By 2021: • 90% of hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.
MEASURE	The percentage of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
DEFINITION	**Numerator:** Number of hospitals with an ED that have written inter-facility transfer agreements that cover pediatric patients according to the data collected. **Denominator:** Total number of hospitals with an ED that provided data. **Units:** 100 **Text:** Percent **Pediatric:** Any person 0 to 18 years of age. **Inter-facility transfer agreements:** Written contracts between a referring facility (e.g., community hospital) and a specialized pediatric center or facility with a **higher level of care** and the appropriate resources to provide needed care required by the child. The agreements must formalize arrangements for consultation and transport of a pediatric patient to the higher-level care facility. Inter-facility agreements do not have to specify transfers of pediatric patients only. An agreement that applies to **all** patients or patients of **all** ages would suffice, as long as it is not written ONLY for adults. Grantees should consult the NRC if they have questions regarding inclusion of pediatric patients in established agreements.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care. Objective 2.5: Develop written pediatric inter-facility transfer agreements to facilitate timely movement of children to appropriate facilities.
DATA SOURCE(S) AND ISSUES	• Surveys of hospitals with an emergency department. • Hospital licensure rules and regulations
SIGNIFICANCE	In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and guidelines.

EMSC 08 PERFORMANCE MEASURE **NO CHANGE FROM PRIOR PM 79**	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system.
GOAL	To increase the number of States/Territories that have established permanence of EMSC in the State/Territory EMS system.
MEASURE	The degree to which States/Territories have established permanence of EMSC in the State/Territory EMS system.
DEFINITION	**Permanence of EMSC in a State/Territory EMS system** is defined as: • The EMSC Advisory Committee has the required members as per the implementation manual. • The EMSC Advisory Committee meets at least four times a year. • By 2011, pediatric representation will have been incorporated on the State/Territory EMS Board. • By 2011, the State/Territory will mandate requiring pediatric representation on the EMS Board. • By 2011, one full time EMSC Manager that is dedicated solely to the EMSC Program will have been established. **EMSC** The component of emergency medical care that addresses the infant, child, and adolescent needs, and the Program that strives to ensure the establishment and permanence of that component. EMSC includes emergent at the scene care as well as care received in the emergency department, surgical care, intensive care, long-term care, and rehabilitative care. EMSC extends far beyond these areas yet for the purposes of this manual this will be the extent currently being sought and reviewed. **EMS system** The continuum of patient care from prevention to rehabilitation, including pre-hospital, dispatch communications, out-of-hospital, hospital, primary care, emergency care, inpatient, and medical home. It encompasses every injury and illness
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 4: Establish permanence of EMSC in each State/Territory EMS system. Objective 4.1: Establish an EMSC Advisory Committee within each State/Territory Objective 4.2: Incorporate pediatric representation on

the State/Territory EMS Board

Objective 4.3: Establish one full-time equivalent EMSC manager that is dedicated solely to the EMSC Program.

DATA SOURCE(S) AND ISSUES

- Attached data collection form to be completed by grantee.

SIGNIFICANCE

Establishing permanence of EMSC in the State/Territory EMS system is important for building the infrastructure of the EMSC Program and is fundamental to its success. For the EMSC Program to be sustained in the long-term and reach permanence, it is important to establish an EMSC Advisory Committee to ensure that the priorities of the EMSC Program are addressed. It is also important to establish one full time equivalent EMSC Manager whose time is devoted solely (i.e., 100%) to the EMSC Program. Moreover, by ensuring pediatric representation on the State/Territory EMS Board, pediatric issues will more likely be addressed.

DATA COLLECTION FORM FOR DETAIL SHEET # EMSC 08

Please indicate the elements that your grant program has established to promote permanence of EMSC in the State/Territory EMS system.

Element	Yes	No
1. The EMSC Advisory Committee has the required members as per the implementation manual.		
2. The EMSC Advisory Committee has met four or more times during the grant year.		
3. There is pediatric representation on the EMS Board.		
4. There is a State/Territory mandate requiring pediatric representation on the EMS Board.		
5. There is one full-time EMSC Manager that is dedicated solely to the EMSC Program.		

Yes = 1
No = 0

Total number of elements your grant program has established (possible 0-5 score) _____

EMSC 09 PERFORMANCE MEASURE **NO CHANGE FROM PRIOR PM 80**	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.
GOAL	By 2021, the six EMSC priorities will have been integrated into existing EMS or hospital/healthcare facility statutes/regulations.
MEASURE	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.
DEFINITION	**Priorities**: The priorities of the EMSC Program include the following six areas: 1. BLS and ALS pre-hospital provider agencies in the State/Territory have on-line and off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility. 2. BLS and ALS patient care units in the State/Territory have the essential pediatric equipment and supplies, as outlined in the nationally recognized and endorsed guidelines. 3. The existence of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage • pediatric medical emergencies • trauma 4. Hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer: • Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication). • Process for selecting the appropriate care facility. • Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.). • Process for patient transfer (including obtaining informed consent). • Plan for transfer of patient medical record • Plan for transfer of copy of signed transport consent • Plan for transfer of personal belongings of the patient • Plan for provision of directions and referral institution information to family 5. Hospitals in the State/Territory have written inter-

facility transfer agreements that cover pediatric patients.

6. The adoption of requirements by the State/Territory for pediatric emergency education for the license/certification renewal of BLS and ALS providers.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 4: Establish permanence of EMSC in each State/Territory EMS system.

DATA SOURCE(S) AND ISSUES

- Attached data collection form to be completed by grantee.

SIGNIFICANCE

For the EMSC Program to be sustained in the long-term and reach permanence, it is important for the Program's priorities to be integrated into existing State/Territory mandates. Integration of the EMSC priorities into mandates will help ensure pediatric emergency care issues and/or deficiencies are being addressed State/Territory-wide for the long-term.

DATA COLLECTION FORM FOR DETAIL SHEET # EMSC 09

Please indicate the elements that your grant program has established to promote the permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.

Element	Yes	No
1. There is a statute/regulation for pediatric on-line medical direction for ALS and BLS pre-hospital provider agencies.		
2. There is a statute/regulation for pediatric off-line medical direction for ALS and BLS pre-hospital provider agencies.		
3. There is a statute/regulation for pediatric equipment for BLS and ALS patient care units.		
4. There is a statute/regulation for a hospital recognition system for identifying hospitals capable of dealing with pediatric medical emergencies.		
5. There is a statute/regulation for a hospital recognition system for identifying hospitals capable of dealing with pediatric traumatic emergencies.		
6. There is a statute/regulation for written inter-facility transfer guidelines that cover pediatric patients and include specific components of transfer.		
7. There is a statute/regulation for written inter-facility transfer agreements that cover pediatric patients.		
8. There is a statute/regulation for the adoption of requirements for continuing pediatric education during recertification of BLS and ALS providers.		

Yes = 1
No = 0

Total number of elements your grant program has established (possible 0-8 score) _____

DIVISION OF HEALTHY START AND PERINATAL SERVICES PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

Performance Measure	New/Revised Measure	Topic
HS 1	New	Reproductive Life Plan
HS 2	New	Medical Home
HS 3	New	Interconception Planning
HS 4	New	Early Elective Delivery
HS 5	New	Perinatal Depression Screening
HS 6	New	Perinatal Depression Follow Up
HS 7	New	Intimate Partner Violence Screening
HS 8	New	Father/ Partner Involvement during Pregnancy
HS 9	New	Father and/or Partner Involvement with child 0-24 Months
HS 10	New	Daily Reading
HS 11	New	CAN implementation
HS 12	New	CAN Participation

HS 01 PERFORMANCE MEASURE **Goal: Reproductive Life Plan** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants that have a documented reproductive life plan.
GOAL	To increase Healthy Start participants who have a documented reproductive life plan to 90%.
MEASURE	The percent of Healthy Start participants that have a documented reproductive life plan.
DEFINITION	**Numerator:** Number of HS participants with reproductive life plan **Denominator:** Number of total HS participants who gave birth
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	HS participants will have a comprehensive reproductive life plan to determine if or when they plan to have children in the future, and identify family planning methods to help them fulfill their plan.

HS 02 PERFORMANCE MEASURE	The percent of Healthy Start participants who have a medical home
Goal 2: Medical Home **Level: Grantee** **Domain: Healthy Start**	
GOAL	To increase proportion of Healthy Start participants who have a medical home to 80%.
MEASURE	The percent of Healthy Start participants who have a medical home.
DEFINITION	**Numerator:** Number of HS participants who have a medical home. **Denominator:** Total number of HS participants.
BENCHMARK DATA SOURCES	Kaiser Family Foundation 2011(Children with a Medical Home 54.4%, 2011), Kaiser Family Foundation 2013 (Adults without a Personal Doctor 23.7%, 2013), National Survey of Children's Health (Children with Medical Home 54.4%, 2011-2012)
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	HS participants should practice safe sleep for their infants. These behaviors include infants sleeping on their backs on clean and firm surfaces, in the absence of smoke, and with no extra bedding (pillows) or toys.

HS 03 PERFORMANCE MEASURE	The percent of Healthy Start participants conceive within 18 months of a previous birth.
Goal: Interconception Planning **Level: Grantee** **Domain: Healthy Start**	
GOAL	To reduce the proportion of HS pregnancies conceived within 18 months of a previous birth to 30%.
MEASURE	The percent of Healthy Start participants conceive within 18 months of a previous birth
DEFINITION	.**Numerator**: Number of HS participants who conceived within 18 months of previous birth **Denominator:** Total number of HS participants who have conceived a prior birth
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	HS participants should space pregnancies at least 18 months apart.

HS 04 PERFORMANCE MEASURE **Goal: Early Elective Delivery** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants with elective delivery before 39 weeks.
GOAL	To reduce the proportion of HS participants with elective delivery before 39 weeks to 10%.
MEASURE	The percent of Healthy Start participants with elective delivery before 39 weeks.
DEFINITION	**Numerator:** Number of HS participants who with elective delivery before 39 weeks. **Denominator:** Total number of births among HS participants (excludes medically indicated deliveries)
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	The elimination of non-medically indicated (elective) deliveries before 39 weeks gestational age.

HS 05 PERFORMANCE MEASURE **Goal: Perinatal Depression Screening** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants who receive perinatal depression screening and referral.
GOAL	To increase the proportion of HS participants who receive perinatal depression screening and referral to 100%.
MEASURE	The percent of Healthy Start participants who receive perinatal depression screening and referral.
DEFINITION	**Numerator:** Number of HS participants who receive perinatal depression screening and referral. **Denominator:** HS participants eligible for perinatal depression screening and referrals.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	All HS participants should receive a perinatal depression screening using an evidence-based depression tool.

HS 06 PERFORMANCE MEASURE **Goal: Perinatal Depression Follow Up** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants who receive follow up services for perinatal depression.
GOAL	To increase proportion of HS participants who receive follow up services for perinatal depression to 90%.
MEASURE	The percent of Healthy Start participants who received follow-up services for perinatal depression.
DEFINITION	**Numerator:** Number of HS participants who received follow-up services for perinatal depression screening. **Denominator:** Total number of Healthy Start participants identified as needing follow-up services.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	HS participants should receive the necessary follow-up services after the completion of the perinatal depression screening.

HS 07 PERFORMANCE MEASURE **Goal: Intimate Partner Violence Screening** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants who receive intimate partner violence screening.
GOAL	Increase the proportion of HS participants who receive intimate partner violence screening to 100%.
MEASURE	The percent of Healthy Start participants who received intimate violence partner screening.
DEFINITION	**Numerator:** Number of HS participants who received intimate partner violence screening. **Denominator:** Total number of Healthy Start participants.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	All HS participants will receive the intimate partner violence (IPV) screening. IPV is a pattern of behavior which involves the abuse by one partner against another in an intimate relationship such as marriage, cohabitation, dating or within the family.

HS 08 PERFORMANCE MEASURE **Goal: Father/ Partner Involvement during pregnancy** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants with father and/or partner involvement during pregnancy.
GOAL	To increase the proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) during pregnancy to 90%.
MEASURE	The percentage of Healthy Start participants with father and/or partner involvement during pregnancy.
DEFINITION	**Numerator:** Number of fathers and/or partners engaged in activities (e.g., attend appointments, classes, infant/child care) with HS participants during pregnancy **Denominator:** Total number of Healthy Start Participants pregnant during the reporting year.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Father and/or partner involvement should consider participation in areas of medical appointments for infants, other children and/or mother, attending HS sponsored classes, prenatal care, care for infant or child during pregnancy.

HS 09 PERFORMANCE MEASURE **Goal: Father and/or Partner Involvement with child 0-24 Months** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants with father and/or partner involvement with child 0-24 months.
GOAL	To increase the proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with child 0-24 months to 80%).
MEASURE	The percentage of Healthy Start participants with father and/or partner involvement with child 0-24 months.
DEFINITION	**Numerator:** Number of fathers and/or partners engaged in activities (e.g., attend appointments, classes, infant/child care) with child 0-24 months **Denominator:** Total number of participants with children between ages 0-24 months.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Father and/or partner involvement should consider participation in areas of medical appointments for infants, children and/or mother, attending HS sponsored classes, prenatal care, care for infant or child, etc.

HS 10 PERFORMANCE MEASURE **Goal: Daily Reading** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants that read daily to a HS child between the ages of 0-24 months.
GOAL	To increase the proportion of HS participants that read daily to a HS child between the ages of 0-24 months to 50%.
MEASURE	The percentage of Healthy Start participants that read daily to a HS child between the ages of 0-24 months.
DEFINITION	**Numerator:** Number of HS participants involved in reading to their children between ages 0-24 months. **Denominator:** Total number of participants with children between ages 0-24 months.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	HS participants (including fathers and partners) should read to infant and/or child.

HS 11 PERFORMANCE MEASURE **Goal : CAN implementation** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants with a fully implemented CAN.
GOAL	To increase the proportion of HS grantees with a fully implemented CAN to 100%.
MEASURE	The percentage of Healthy Start participants with a fully implemented CAN.
DEFINITION	**Numerator:** Number of HS grantees with CAN **Denominator:** Total number of HS grantees
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	CAN is an existing, formally organized partnership, advisory board or coalition of organizations and individuals representing consumers and appropriate agencies who unite in an effort to collective apply their resources to the implementation of one or more common strategies to achieve a common goal within that project area.

HS 12 PERFORMANCE MEASURE **Goal : CAN participation** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants with 25% participant membership on their CAN.
GOAL	To increase the proportion of HS grantees with at least 25% HS participant membership on their CAN to 100%.
MEASURE	The percentage of Healthy Start participants with 25% participant membership on their CAN.
DEFINITION	**Numerator:** Number of total HS participants in CAN **Denominator:** Total number of CAN membership
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	HS participants must have active membership in CAN.

DIVISION OF CHILDREN WITH SPECIAL HEALTH NEEDS
Family to Family Health Information Center Program
PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

Performance Measure	New/Revised Measure	Previous Performance Measure Number	Topic
F2F 1	Revised	70	Provide National Leadership for families with children with special health needs

F2F 1 PERFORMANCE MEASURE **Goal: Provide National Leadership for families with children with special health needs** **Level: Grantee** **Category: Family Participation**	The percent of families with Children with Special Health Care Needs (CSHCN) that have been provided information, education, and/or training by Family-to-Family Health Information Centers.
GOAL	To increase the number of families with CSHCN receiving needed health and related information, training, and/or education opportunities in order to partner in decision making and be satisfied with services that they receive.
MEASURE	The percent of families with CSHCN that have been provided information, education and/or training by Family-to-Family Health Information Centers.
DEFINITION	**Numerator:** The total number of families with CSHCN in the State that have been provided information, education, and/or training from Family-To-Family Health Information Centers. **Denominator:** The estimated number of families with CSHCN in the State **Units:** 100 **Text:** Percent
BENCHMARK DATA SOURCES	Related to Objective MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems
GRANTEE DATA SOURCES	Progress reports from Family-To-Family Health Care Information and Education Centers, National Survey for Children's Health (NSCH), Title V Information System
SIGNIFICANCE	The last decade has emphasized the central role of families as informed consumers of services and participants in policy-making activities. Research has indicated that families need information they can understand and information from other parents who have experiences similar to theirs and who have navigated services systems.

DATA COLLECTION FORM FOR DETAIL SHEET #F2F 1

A. PROVIDING INFORMATION, EDUCATION, AND/OR TRAINING

Estimated number of families with CSHCN in the State: _____

1. Our organization provided one-on-one health care information (including referrals)/education/training/peer support to families with CSHCN to assist them in accessing information and services.

a. Total number of families served/trained: _____

b. Of the total number of families served/trained, how many families identified themselves as

Ethnicity

1. Hispanic
2. Non-Hispanic

Race

1. White
2. Black or African American
3. Asian
4. Native Hawaiian or Pacific Islander
5. Some other Race
6. Unknown

c. Total instances of service/training provided (this will be a duplicated count): _____

d. Of the total instances of service, how many provided

1. Individualized assistance (Includes one-on-one instruction, consultation, counseling, case management, and mentoring) _____
2. Basic contact information and referrals _____
3. Group training opportunities _____
4. Meetings/Conferences and Public Events (includes outreach events and presentations) _____

e. Of the total number of families served/trained, how many instances of service related to the following issues:

1. Partnering/decision making with providers
   Number of families served/trained _____
2. Accessing a medical home
   Number of families served/trained _____
3. Financing for needed health services
   Number of families served/trained _____
4. Early and continuous screening
   Number of families served/trained _____
5. Navigating systems/accessing community services easily
   Number of families served/trained _____
6. Adolescent transition issues
   Number of families served/trained _____
7. Other (Specify): _____
   Number of families served/trained _____

2. Our organization provided health care information/education to professionals/providers to assist them in better providing services for CSHCN.

a. Total number of professionals/providers served/trained: _____

b. Total instances of service/training provided (this will be a duplicated count): _____

c. Of the total number of professionals/providers served/trained, how many instances of service were used to provide health care information/education related to the following issues:

1. Partnering/decision making with families
   Number of professionals/providers served/trained: _____
2. Accessing/providing a medical home
   Number of professionals/providers served/trained: _____
3. Financing for needed services
   Number of professionals/providers served/trained: _____
4. Early and continuous screening
   Number of professionals/providers served/trained: _____
5. Navigating systems/accessing community services easily
   Number of professionals/providers served/trained: _____
6. Adolescent transition issues
   Number of professionals/providers served/trained: _____
7. Other (Specify):_____
   Number of professionals/providers served/trained: _____

3. Our organization conducted communication and outreach to families and other appropriate entities through a variety of methods.

a. Total number print/media information and resources disseminated via
   - Hardcopy only _____
   - Electronic newsletters and listservs _____
   - Social media platforms _____
   - Text messaging _____
   - Unique web visits _____
   - Other (Specify): _____

4. Our organization worked with State agencies/programs to assist them with providing services to their populations and/or to obtain their information to better serve our families.

a. Types of State agencies/programs - Total: _____

b. Indicate the types of State agencies/programs with which your organization has worked:

b. State level Commissions, Task Forces, etc.
c. MCH/CSHCN
d. Genetics/newborn screening
e. Early Hearing Detection and Intervention/Newborn Hearing screening
f. Emergency Medical Services for Children
g. LEND Programs
h. Oral Health
i. NICHQ Learning Collaboratives
j. Developmental Disabilities
k. Medicaid (CMS),SCHIP

l. Private Insurers
m. Case Managers
n. SAMHSA/Mental & Behavioral Health
o. Federation of Families for Children's Mental Health
p. HUD/housing
q. Early Intervention/Head Start
r. Education
s. Child Care
t. Juvenile Justice/Judicial System
u. Foster Care/Adoption agencies
v. Other (Specify): _____
w. None

B. MODELS OF FAMILY ENGAGEMENT COLLABORATION

1. Our organization served/worked with community-based organizations to assist them with providing services to their populations and/or to obtain their information to better serve our families.

a. Types of community-based organizations - Total: _____

b. Indicate the types of community-based organizations with which your organization has worked:

- Other family organizations, groups
- Medical homes, providers, clinics
- American Academy of Pediatrics Chapter
- Hospitals - Residents, hospital staff training
- Hospitals - Other:_____
- Universities - Schools of Public Health
- Universities - Schools of Nursing
- Universities - Schools of Social Work
- Community Colleges
- Schools
- Interagency groups
- Faith-based organizations, places of worship
- Non-Profits, such as United Cerebral Palsy, March of Dimes, etc)
- Ethnic/racial specific organizations
- Community Teams
- Other (Specify): _____
- None

2. Family-to-Family Health Information Center goals/objectives were accomplished through formal and informal partnership strategies and practices.

a. Number of agreements with partners (from partners identified in items 3 and 4). Total _____

b. Indicate the type of partnership agreements that were in place during the reporting period:
   - Subcontract
   - Memorandum of Understanding/Agreement
   - Letter of Invitation/Acceptance/Support
   - Informal/Verbal Arrangement

- Other (Specify): _____

7. **Our organization is staffed by families with expertise in Federal and State public and private health care systems.**
   a. Number of Family-to-Family FTE _____

   b. Number of FTE who are family/have a disability _____

Health Resources and Services Administration
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

OMB No. 0915-0298
Expires:_____

Attachment C
Part 2-
Financial and Demographic Data Elements

OMB Clearance Package

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Table of Contents

Forms

FORM 1
MCHB PROJECT BUDGET DETAILS FOR FY _____

1.	**MCHB GRANT AWARD AMOUNT**		$
2.	**UNOBLIGATED BALANCE**		$
3.	**MATCHING FUNDS**		$
	(Required: Yes [ ] No [ ] If yes, amount)		
	A. Local funds	$	
	B. State funds	$	
	C. Program Income	$	
	D. Applicant/Grantee Funds	$	
	E. Other funds: _____	$	
4.	**OTHER PROJECT FUNDS** (Not included in 3 above)		$
	A. Local funds	$	
	B. State funds	$	
	C. Program Income (Clinical or Other)	$	
	D. Applicant/Grantee Funds (includes in-kind)	$	
	E. Other funds (including private sector, e.g., Foundations)	$	
5.	**TOTAL PROJECT FUNDS** (Total lines 1 through 4)		$
6.	**FEDERAL COLLABORATIVE FUNDS**		$
	(Source(s) of additional Federal funds contributing to the project)		
	A. Other MCHB Funds (Do not repeat grant funds from Line 1)		
	1) Special Projects of Regional and National Significance (SPRANS)	$	
	2) Community Integrated Service Systems (CISS)	$	
	3) State Systems Development Initiative (SSDI)	$	
	4) Healthy Start	$	
	5) Emergency Medical Services for Children (EMSC)	$	
	6) Combating Autism Act Initiative	$	
	7) Patient Protection and Affordable Care Act		
	8) Universal Newborn Hearing Screening		
	9) State Title V Block Grant	$	
	10) Other: _____	$	
	11) Other: _____	$	
	12) Other: _____	$	
	B. Other HRSA Funds		
	1) HIV/AIDS	$	
	2) Primary Care	$	
	3) Health Professions	$	
	4) Other: _____	$	
	5) Other: _____	$	
	6) Other: _____	$	
	C. Other Federal Funds		
	1) Center for Medicare and Medicaid Services (CMS)	$	
	2) Supplemental Security Income (SSI)	$	
	3) Agriculture (WIC/other)	$	
	4) Administration for Children and Families (ACF)	$	
	5) Centers for Disease Control and Prevention (CDC)	$	
	6) Substance Abuse and Mental Health Services Administration (SAMHSA)	$	
	7) National Institutes of Health (NIH)	$	
	8) Education	$	
	9) Bioterrorism		
	10) Other: _____	$	
	11) Other: _____	$	
	12) Other _____	$	
7.	**TOTAL COLLABORATIVE FEDERAL FUNDS**	$	

INSTRUCTIONS FOR COMPLETION OF FORM 1
MCH BUDGET DETAILS FOR FY ____

Line 1. Enter the amount of the Federal MCHB grant award for this project.

Line 2. Enter the amount of carryover (e.g, unobligated balance) from the previous year's award, if any. New awards do not enter data in this field, since new awards will not have a carryover balance.

Line 3. If matching funds are required for this grant program list the amounts by source on lines 3A through 3E as appropriate. Where appropriate, include the dollar value of in-kind contributions.

Line 4. Enter the amount of other funds received for the project, by source on Lines 4A through 4E, specifying amounts from each source. Also include the dollar value of in-kind contributions.

Line 5. Displays the sum of lines 1 through 4.

Line 6. Enter the amount of other Federal funds received on the appropriate lines (A.1 through C.12) **other** than the MCHB grant award for the project. Such funds would include those from other Departments, other components of the Department of Health and Human Services, or other MCHB grants or contracts.

Line 6C.1. Enter only project funds from the Center for Medicare and Medicaid Services. Exclude Medicaid reimbursement, which is considered Program Income and should be included on Line 3C or 4C.

If lines 6A.8-10, 6B .4-6, or 6C.10-12 are utilized, specify the source(s) of the funds in the order of the amount provided, starting with the source of the most funds. .

Line 7. Displays the sum of lines in 6A.1 through 6C.12.

FORM 2
PROJECT FUNDING PROFILE

	FY ____		FY ____		FY ____		FY ____		FY ____	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1 MCHB Grant Award Amount *Line 1, Form 2*	$	$	$	$	$	$	$	$	$	$
2 Unobligated Balance *Line 2, Form 2*	$	$	$	$	$	$	$	$	$	$
3 Matching Funds (If required) *Line 3, Form 2*	$	$	$	$	$	$	$	$	$	$
4 Other Project Funds *Line 4, Form 2*	$	$	$	$	$	$	$	$	$	$
5 Total Project Funds *Line 5, Form 2*	$	$	$	$	$	$	$	$	$	$
6 Total Federal Collaborative Funds *Line 7, Form 2*	$	$	$	$	$	$	$	$	$	$

INSTRUCTIONS FOR THE COMPLETION OF FORM 2
PROJECT FUNDING PROFILE

Instructions:

Complete all required data cells. If an actual number is not available, use an estimate. Explain all estimates in a note.

The form is intended to provide funding data at a glance on the estimated budgeted amounts and actual expended amounts of an MCH project.

For each fiscal year, the data in the columns labeled Budgeted on this form are to contain the same figures that appear on the Application Face Sheet (for a non-competing continuation) or the Notice of Grant Award (for a performance report). The lines under the columns labeled Expended are to contain the actual amounts expended for each grant year that has been completed.

FORM 3
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED
For Projects Providing Direct Health Care, Enabling, or Population-based Services

	FY_____		**FY_____**	
Target Population(s)	$ Budgeted	$ Expended	$ Budgeted	$ Expended
Pregnant Women (All Ages)				
Infants (Age 0 to 1 year)				
Children (Age 1 year to 12 years)				
Adolescents (Age 12 to 18 years)				
CSHCN Infants (Age 0 to 1 year)				
CSHCN Children and Youth (Age 1 year to 25 years)				
Non-pregnant Women (Age 25 and over)				
Other				
TOTAL				

INSTRUCTIONS FOR COMPLETION OF FORM 3
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED

For Projects Providing Direct Services, Enabling, or Public Health Servicesand Systems

If the project provides direct services, complete all required data cells for all years of the grant. If an actual number is not available make an estimate. Please explain all estimates in a note.

All ages are to be read from x to y, not including y. For example, infants are those from birth to 1, and children and youth are from age 1 to 25.

Enter the budgeted amounts for the appropriate fiscal year, for each targeted population group. Note that the Total for each budgeted column is to be the same as that appearing in the corresponding budgeted column in Form 2, Line 5.

Enter the expended amounts for the appropriate fiscal year that has been completed for each target population group. Note that the Total for the expended column is to be the same as that appearing in the corresponding expended column in Form 2, Line 5.

.

FORM 4
PROJECT BUDGET AND EXPENDITURES
By Types of Services

	TYPES OF SERVICES	FY _____ Budgeted	FY _____ Expended	FY _____ Budgeted	FY _____ Expended
I.	**Direct Health Care Services** (Basic Health Services and Health Services for CSHCN.)	$	$	$	$
II.	**Enabling Services** (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC and Education.)	$	$	$	$
III.	**Public Health Services and Systems** (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systen Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$	$	$	$
IV.	*TOTAL*	$	$	$	$

INSTRUCTIONS FOR THE COMPLETION OF FORM 4
PROJECT BUDGET AND EXPENDITURES BY TYPES OF SERVICES

Complete all required data cells for all years of the grant. If an actual number is not available, make an estimate. Please explain all estimates in a note. Administrative dollars should be allocated to the appropriate level(s) of the pyramid on lines I, II, II or IV. If an estimate of administrative funds use is necessary, one method would be to allocate those dollars to Lines I, II, III and IV at the same percentage as program dollars are allocated to Lines I through IV.

Note: Lines I, II and II are for projects providing services. If grant funds are used to build the infrastructure for direct care delivery, enabling or population-based services, these amounts should be reported in Line IV (i.e., building data collection capacity for newborn hearing screening).

Line I Direct Health Care Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Direct Health Care Services are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Line II Enabling Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Enabling Services allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Line III Public Health Services and Systems - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Public Health Services and Systems include preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not. The other critical aspect of Public Health Services and Systems are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources such as health services standards/guidelines, training, data and planning systems. Examples

include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Line V Total – Displays the total amounts for each column, budgeted for each year and expended for each year completed.

FORM 5
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care, Enabling or Population-based Services

Reporting Year_____

Table 1

Pregnant Women Served	(a) **Number Served**	(b) **Total Served**	(c) **Title XIX %**	(d) **Title XXI %**	(e) **Private/ Other %**	(f) **None %**	(g) **Unknown %**
Pregnant Women (All Ages)							
10-14							
15-19							
20-24							
25-34							
35-44							
45 +							

Table 2

Infants, Children and Youth Served	(a) **Number Served**	(b) **Total Served**	(c) **Title XIX %**	(d) **Title XXI %**	(e) **Private/ Other %**	(f) **None %**	(g) **Unknown %**
Infants <1							
Children and Youth 1 to 25 years							
12-24 months							
25 months-4 years							
5-9							
10-14							
15-19							
20-24							

Table 3

CSHCN Infants, Children and Youth Served	(a) **Number Served**	(b) **Total Served**	(c) **Title XIX %**	(d) **Title XXI %**	(e) **Private/ Other %**	(f) **None %**	(g) **Unknown %**
Infants <1 yr							
Children and Youth 1 to 25 years							
12-24 months							
25 months-4 years							
5-9							
10-14							
15-19							

20-24							

Table 4

Women Served	(a) **Number Served**	(b) **Total Served**	(c) **Title XIX %**	(d) **Title XXI %**	(e) **Private/ Other %**	(f) **None %**	**Unknown %** (g)
Women 25+							
25-29							
30-34							
35-44							
45-54							
55-64							
65+							

Table 5

Other	(a) **Number Served**	(b) **Total Served**	(c) **Title XIX %**	(d) **Title XXI %**	(e) **Private/ Other %**	(f) **None %**	**Unknown %** (g)
Men 25+							

TOTAL SERVED: _____

INSTRUCTIONS FOR THE COMPLETION OF FORM 5

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care, Enabling or Population-based Services

Enter data into all required (unshaded) data cells. If an actual number is not available, make an estimate. Please explain all estimates, in a note.

Note that ages are expressed as either x to y, (i.e., 1 to 25, meaning from age 1 up to age 18, but not including 25) or x – y (i.e., 1 – 4 meaning age 1 through age 4). Also, symbols are used to indicate directions. For example, <1 means less than 1, or from birth up to, but not including age 1. On the other hand, 45+ means age 45 and over.

1. At the top of the Form, the Line Reporting Year displays the year for which the data applies.

2. In Column (a), enter the unduplicated count of individuals who received a direct service from the project regardless of the primary source of insurance coverage. These services are those that are done by any non-capacity building services and would include individuals served by total dollars reported on Form 3, Line 5.

3. In Column (b), the total number of the individuals served is summed from Column (a).

4. In the remaining columns, report the percentage of those individuals receiving direct health care, enabling or population-based services, who have as their primary source of coverage:
   Column (c): Title XIX (includes Medicaid expansion under Title XXI)
   Column (d): Title XXI
   Column (e): Private or other coverage
   Column (f): None
   Column (g): Unknown

   These may be estimates. If individuals are covered by more than one source of insurance, they should be listed under the column of their primary source.

REVISED FORM 6
MATERNAL & CHILD HEALTH DISCRETIONARY GRANT
PROJECT ABSTRACT
FOR FY____

PROJECT:_____

I. PROJECT IDENTIFIER INFORMATION

1. Project Title:
2. Project Number:
3. E-mail address:

II. BUDGET

1. MCHB Grant Award (Line 1, Form 2) $_____
2. Unobligated Balance (Line 2, Form 2) $_____
3. Matching Funds (if applicable) (Line 3, Form 2) $_____
4. Other Project Funds (Line 4, Form 2) $_____
5. Total Project Funds (Line 5, Form 2) $_____

III. TYPE(S) OF SERVICE PROVIDED (Choose all that apply)

[ ] Direct Services
[ ] Enabling Services
[ ] Public Health Services and Systems

IV. DOMAIN SERVICES ARE PROVIDED TO

[ ] **Maternal/ Women's' Health**
[ ] **Perinatal/ Infant Health**
[ ] **Child Health**
[ ] **Children with Special Health Care Needs**
[ ] **Adolescent Health**
[ ] **Life Course/ All Population Domains**
[ ] **Local/ State/ National Capacity Building**

V. PROJECT DESCRIPTION OR EXPERIENCE TO DATE

A. Project Description

1. Problem (in 50 words, maximum):

2. Aims and Key Activities: (List up to 5 major aims and key related activities for the project. These should reflect the aims from the FOA, also these will be used for Grant Impact measurement at the end of your grant period)

Aim 1:
Related Activity 1:
Related Activity 2:
Aim 2:
Related Activity 1:
Related Activity 2:
Aim 3:
Related Activity 1:
Related Activity 2:

Aim 4:
Related Activity 1:
Related Activity 2:
Aim 5:
Related Activity 1:
Related Activity 2:

3. Specify the primary *Healthy People 2020* objectives(s) (up to three) which this project addresses:

a.

b.

c.

5. Coordination (List the State, local health agencies or other organizations involved in the project and their roles)

6. Evaluation (briefly describe the methods which will be used to determine whether process and outcome objectives are met, be sure to tie to evaluation from FOA.)
7. Quality Improvement Activities

B. Continuing Grants ONLY

1. Experience to Date (For continuing projects ONLY):

V. KEY WORDS

VI. ANNOTATION

REVISED INSTRUCTIONS FOR THE COMPLETION OF FORM 6
PROJECT ABSTRACT

NOTE: All information provided should fit into the space provided in the form. The completed form should be no more than 3 pages in length. Where information has previously been entered in forms 1 through 5, the information will automatically be transferred electronically to the appropriate place on this form.

Section I – Project Identifier Information

Project Title: Displays the title for the project.
Project Number: Displays the number assigned to the project (e.g., the grant number)
E-mail address: Displays the electronic mail address of the project director

Section II – Budget - These figures will be transferred from Form 1, Lines 1 through 5.

Section III - Types of Services

Indicate which type(s) of services your project provides, checking all that apply.

Section IV – Program Description OR Current Status (DO NOT EXCEED THE SPACE PROVIDED)

A. New Projects only are to complete the following items:
   1. A brief description of the project and the problem it addresses, such as preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for Children with Special Health Care Needs.
   2. Provide up to 5 aims of the project, in priority order. Examples are: To reduce the barriers to the delivery of care for pregnant women, to reduce the infant mortality rate for minorities and "services or system development for children with special healthcare needs." MCHB will capture annually every project's top aims in an information system for comparison, tracking, and reporting purposes; you must list at least 1 and no more than 5 aims. For each goal, list thekey related activities. The aims and activities must be specific and time limited (i.e. Aim 1: increase providers in area trained in providing quality well-child visits by 10% by 20017 through 1. trainings provided at state pediatric association and 2. on-site technical assistance).
   3. Displays the primary Healthy people 2020 goal(s) that the project addresses.
   4. Describe the programs and activities used to reach aims, and comment on innovation, cost, and other characteristics of the methodology, proposed or are being implemented. Lists with numbered items can be used in this section.
   5. Describe the coordination planned and carried out, in the space provided, if applicable, with appropriate State and/or local health and other agencies in areas(s) served by the project.
   6. Briefly describe the evaluation methods that will be used to assess the success of the project in attaining its aims and implementing activities.

B. For continuing projects ONLY:
   1. Provide a brief description of the major activities and accomplishments over the past year (not to exceed 200 words).
   2. If applicable, provide the number of hits by unique visitors to the website (or section of website) funded by MCHB for the past year.

Section V – Key Words

Provide up to 10 key words to describe the project, including populations served. Choose key words from the included list.

Section VI – Annotation

Provide a three- to five-sentence description of your project that identifies the project's purpose, the needs and problems, which are addressed, the aims of the project, the related activitieswhich will be used to meet the aims, and the materials, which will be developed.

FORM 7
DISCRETIONARY GRANT PROJECT
SUMMARY DATA

1. Project Service Focus

[ ] Urban/Central City [ ] Suburban [ ] Metropolitan Area (city & suburbs)
[ ] Rural [ ] Frontier [ ] Border (US-Mexico)

2. Project Scope

[ ] Local [ ] Multi-county [ ] State-wide
[ ] Regional [ ] National

3. Grantee Organization Type

[ ] State Agency
[ ] Community Government Agency
[ ] School District
[ ] University/Institution Of Higher Learning (Non-Hospital Based)
[ ] Academic Medical Center
[ ] Community-Based Non-Governmental Organization (Health Care)
[ ] Community-Based Non-Governmental Organization (Non-Health Care)
[ ] Professional Membership Organization (Individuals Constitute Its Membership)
[ ] National Organization (Other Organizations Constitute Its Membership)
[ ] National Organization (Non-Membership Based)
[ ] Independent Research/Planning/Policy Organization
[ ] Other _____

5. Demographic Characteristics of Project Participants

Indicate the service level:

☐	**Direct Health Care Services**
☐	**Enabling Services**
☐	**Public Health Services and Systems**

	RACE (Indicate all that apply)								**ETHNICITY**			
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More than One Race	Unrecorded	Total	Hispanic or Latino	Not Hispanic or Latino	Unrecorded	Total
Pregnant Women (All Ages)												
Infants <1 year												
Children 1 to 12 years												
Adolescents 12-18 years												
Young Adults 18-25 years												
CSHCN Infants <1 year												
CSHCN Children and Youth 1 to 25 years												
Women 25+ years												
Men 25+												
TOTALS												

6. Clients' Primary Language(s)

_____
_____
_____

~~7~~.8. Resource/TA and Training Centers ONLY

Answer all that apply.

a. Characteristics of Primary Intended Audience(s)
   - [ ] Providers/ Professionals
   - [ ] Local/ Community partners
   - [ ] Title V
   - [ ] Other state agencies/ partners
   - [ ] Regional
   - [ ] National
   - [ ] International

b. Number of Requests Received/Answered: ___/____
c. Number of Continuing Education credits provided: _____
d. Number of Individuals/Participants Reached: _____
e. Number of Organizations Assisted: _____
f. Major Type of TA or Training Provided:
   - [ ] continuing education courses,
   - [ ] workshops,
   - [ ] on-site assistance,
   - [ ] distance learning classes
   - [ ] one-on-one remote consultation
   - [ ] other, Specify:_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 7
PROJECT SUMMARY

Section 1 – Project Service Focus
Select all that apply

Section 2 – Project Scope
Choose the one that best applies to your project.

Section 3 – Grantee Organization Type
Choose the one that best applies to your organization.

Section 4 – Project Infrastructure Focus
If applicable, choose all that apply.

Section 5 – Demographic Characteristics of Project Participants
Indicate the service level for the grant program. Multiple selections may be made.. Please fill in each of the cells as appropriate.

Direct Health Care Services are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Public Health Services and Systems include preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not. The other critical aspect of **Public Health Services and Systems** are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources such as health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Section 6 – Clients Primary Language(s)
Indicate which languages your clients speak as their primary language, other than English, for the data provided in Section 6. List up to three languages.

Section 7 – Check all population served

Section 8 – Resource/TA and Training Centers (Only)
Answer all that apply.

FORM 8
(For Research Projects ONLY)
MATERNAL & CHILD HEALTH DISCRETIONARY GRANT
PROJECT ABSTRACT
FOR FY____

I. PROJECT IDENTIFIER INFORMATION

1. Project Title:
2. Project Number:
3. Project Director:
4. Principle Investigator(s), Discipline

II. BUDGET

1. MCHB Grant Award (Line 1, Form 2) $_____
2. Unobligated Balance (Line 2, Form 2) $_____
3. Matching Funds (if applicable) (Line 3, Form 2) $_____
4. Other Project Funds (Line 4, Form 2) $_____
5. Total Project Funds (Line 5, Form 2) $_____

III. CARE EMPHASIS

[ ] Interventional
[ ] Non-interventional

IV. POPULATION FOCUS

[ ] Neonates
[ ] Infants
[ ] Toddlers
[ ] Preschool Children
[ ] School-Aged Children
[ ] Adolescents
[ ] Adolescents (Pregnancy Related)
[ ] Young Adults (>20)
[ ] Pregnant Women
[ ] Postpartum Women
[ ] Parents/Mothers/Fathers
[ ] Adolescent Parents
[ ] Grandparents
[ ] Physicians
[ ] Others

V. STUDY DESIGN

[ ] Experimental
[ ] Quasi-Experimental
[ ] Observational

VI. TIME DESIGN

[ ] Cross-sectional
[ ] Longitudinal
[ ] Mixed

VII. PRIORITY RESEARCH ISSUES AND QUESTIONS OF FOCUS

From the Maternal and Child Health Bureau (MCHB) Strategic Research Issues: Fiscal Years (FYs) 2004 – 2009.

Primary area addressed by research:

Secondary area addressed by research:

VIII. ABSTRACT

IX. KEY WORDS

X. ANNOTATION

INSTRUCTIONS FOR THE COMPLETION OF FORM 8
MATERNAL & CHILD HEALTH
RESEARCH PROJECT ABSTRACT

NOTE: All information provided should fit into the space provided in the form. Do not exceed the space provided.

Where information has previously been entered in forms 1 through 5, the information will automatically be transferred electronically to the appropriate place on this form.

Section I – Project Identifier Information

Project Title:	Displays the title for the project.
Project Number:	Displays the number assigned to the project (e.g., the grant number).
Project Director:	Displays the name and degree(s) of the project director as listed on the grant application.
Principal Investigator:	Enter the name(s) and discipline(s) of the principal investigator(s).

Section II – Budget

The amounts for Lines 1 through 5 will be transferred from Form 1, Lines 1 through 5.

Section III – Care Emphasis

Indicate whether the study is interventional or non-interventional.

Section IV – Population Focus

Indicate which population(s) are the focus of the study. Check all that apply.

Section V – Study Design

Indicate which type of design the study uses.

Section VI – Time Design

Indicate which type of design the study uses.

Section VII – Priority Research Issues and Questions of Focus (DO NOT EXCEED THE SPACE PROVIDED)

Provide a brief statement of the primary and secondary (if applicable) areas to be addressed by the research. The topic(s) should be from those listed in the *Maternal and Child Health Bureau (MCHB) Strategic Research Issues: Fiscal Years (FYs) 2004 – 2009*).

Section VIII – Abstract

Section IX - -Key Words

Provide up to 10 key words to describe the project, including populations served. A list of key words used to classify active projects is included. Choose keywords from this list when describing your project.

Section X – Annotation

Provide a three- to five-sentence description of your project that identifies the project's purpose, the needs and problems which are addressed, the aims of the project, the related activities which will be used to meet the stated aims, and the materials, which will be developed.

Health Resources and Services Administration
Maternal and Child Health Bureau

Discretionary Grant Program Performance Measures

OMB No. 0915-0298
Expires: _____

Attachment D
Part 3
Additional Data Elements

OMB Clearance Package

Table of Contents

Forms

TECHNICAL ASSISTANCE/COLLABORATION FORM

DEFINITION: Technical Assistance/Collaboration refers to mutual problem solving and collaboration on a range of issues, which may include program development, clinical services, collaboration, program evaluation, needs assessment, and policy & guidelines formulation. It may include administrative services, site visitation and review/advisory functions. Collaborative partners might include State or local health agencies, and education or social service agencies. Faculty may serve on advisory boards to develop &/or review policies at the local, State, regional, national or international levels. The technical assistance (TA) effort may be a one-time or on-going activity of brief or extended frequency. The intent of the measure is to illustrate the reach of the training program beyond trainees.

Provide the following summary information on **ALL** TA provided

Total Number of Technical Assistance/Collaboration Activities	**TA Activities by Type of Recipient**	**Number of TA Activities by Target Audience**
_____	☐ Other Divisions/ Departments in a University ☐ Title V (MCH Programs) ☐ State Health Dept. ☐ Health Insurance/ Organization ☐ Education ☐ Medicaid agency ☐ Social Service Agency ☐ Mental Health Agency ☐ Juvenile Justice or other Legal Entity ☐ State Adolescent Health ☐ Developmental Disability Agency ☐ Early Intervention ☐ Other Govt. Agencies ☐ Mixed Agencies ☐ Professional Organizations/Associations ☐ Family and/or Consumer Group ☐ Foundations ☐ Clinical Programs/ Hospitals ☐ Other: Please Specify_____	_____ Local _____ Title V _____ Within State _____ Another State _____ Regional _____ National _____ International _____

B. Provide information below on the **5-10 most significant** technical assistance/collaborative activities in the past year. In the notes, briefly state why these were the most significant TA events.

Title	**Topic of Technical Assistance/Collaboration** *Select one from list A and all that apply from List B.*		**Recipient of TA/Collaborator**	**Intensity of TA**	**Primary Target Audience**
	List A (select one) A. Clinical care related (including medical home) B. Cultural Competence Related C. Data, Research, Evaluation Methods (Knowledge Translation) D. Family Involvement E. Interdisciplinary Teaming F. Healthcare Workforce Leadership G. Policy H. Prevention I. Systems Development/ Improvement	List B (select all that apply) 1. Prenatal Care 2. Perinatal/ Postpartum Care 3. Well Woman Visit/ Preventive Health Care 4. Depression Screening 5. Severe Maternal Mortality/Morbidity 6. Safe Sleep 7. Breastfeeding 8. Newborn Screening 9. Quality of Well Child Visit 10. Child Well Visit 11. Injury Prevention 12. Family Engagement 13. Medical Home (Access to and use of medical home) 14. Transition 15. Adolescent Well Visit 16. Injury Prevention 17. Screening for Major Depressive Disorder 18. Health Equity 19. Adequate health insurance coverage 20. Tobacco and eCigarette Use 21. Oral Health 22. Nutrition	A. Other Divisions/ Departments in a University B. Title V (MCH Programs) C. State Health Dept. D. Health Insurance/ Organization E. Education F. Medicaid agency G. Social Service Agency H. Mental Health Agency I. Juvenile Justice or other Legal Entity J. State Adolescent Health K. Developmental Disability Agency L. Early Intervention M. Other Govt. Agencies N. Mixed Agencies O. Professional Organizations/Associations P. Family and/or Consumer Group Q. Foundations R. Clinical Programs/ Hospitals	1. One time brief (single contact) 2. One time extended (multi-day contact provided one time) 3. On-going infrequent (3 or less contacts per year) 4. On-going frequent (more than 3 contacts per year)	1. Local 2. Title V 3. Within State 4. Another State 5. Regional 6. National 7. International

				S. Other (specify)		
1	Example	G- Policy	21- Oral Health	E - Education	2	2

C. In the past year have you provided technical assistance on emerging issues that are not represented in the topic list above? YES/ NO.

If yes, specify the topic(s):_____

CONTINUING EDUCATION FORM

Continuing Education is defined as continuing education programs or trainings that serve to enhance the knowledge and/or maintain the credentials and licensure of professional providers. Training may also serve to enhance the knowledge base of community outreach workers, families, and other members who directly serve the community.

A. Provide information related to the total number of CE activities provided through your training program last year.

Total Number of CE Participants _____
Total Number of CE Sessions/Activities _____

Number of CE Sessions/Activities by Primary Target Audience
- Number of **Local** CE Activities _____
- Number of **Within State** CE Activities _____
- Number of CE Activities in **Another State** _____
- Number of **Regional** CE Activities _____
- Number of **National** CE Activities
- Number of **International** CE Activities _____

_____

Number of CE Sessions/Activities for which Credits are Provided _____

For **up to 10** of the most significant CE activities in the past project year, list the title, topics, methods, number of participants, duration and whether CE units were provided. In the field notes, briefly state why these were the most significant CE events (e.g., most participants reached; key topic addressed, new collaboration opportunity, emerging issues, diversity of participants (other than healthcare workers etc))

Title	**Topic: List A** select one A. Clinical Care-Related (including medical home) B. Cultural Competence-Related C. Data, Research, Evaluation Methods (Knowledge Translation) D. Family Involvement E. Interdisciplinary Teaming F. Healthcare Workforce Leadership G. Policy H. Prevention I. Systems Development/ Improvement	**Topic: List B:** *select all that apply* 1. Prenatal Care 2. Perinatal/ Postpartum Care 3. Well Woman Visit/ Preventive Health Care 4. Depression Screening 5. Severe Maternal Mortality/Morbidity 6. Safe Sleep 7. Breastfeeding 8. Newborn Screening 9. Quality of Well Child Visit 10. Child Well Visit 11. Injury Prevention 12. Family Engagement 13. Medical Home (Access to and use of medical home) 14. Transition 15. Adolescent Well Visit 16. Injury Prevention 17. Screening for Major Depressive Disorder 18. Health Equity 19. Adequate health insurance coverage 20. Tobacco and eCigarette Use 21. Oral Health 22. Nutrition	**Primary Target Audience** 1. Local 2. Within State 3. Another state 4. Regional 5. National 6. International	**Method*** A. In-person B. Live Online C. On-Demand Online D. By phone/ conference call E. Mixed	**Number of Participants**	**Continuing Education Credits Provided?** (Yes/No)
1.						
2.						
3.						

C. In the past year have you provided continuing education on emerging issues that are not represented in the topic list above?
YES/ NO. If yes, specify the topic(s):_____

REVISED

Products, Publications and Submissions Data Collection Form

Part 1

Instructions: Please list the number of products, publications and submissions addressing maternal and child health that have been published or produced by your staff during the reporting period (counting the original completed product or publication developed, not each time it is disseminated or presented). Products and Publications include the following types:

Type	Number
In Press peer-reviewed publications in scholarly journals *Please include peer reviewed publications addressing maternal and child health that have been published by project faculty and/or staff during the reporting period. Faculty and staff include those listed in the budget form and narrative and others that your program considers to have a central and ongoing role in the project whether they are supported or not supported by the grant.*	
Submission(s) of peer-reviewed publications to scholarly journals	
Books	
Book chapters	
Reports and monographs (including policy briefs and best practices reports)	
Conference presentations and posters presented	
Web-based products (Blogs, podcasts, Web-based video clips, wikis, RSS feeds, news aggregators, social networking sites)	
Electronic products (CD-ROMs, DVDs, audio or videotapes)	
Press communications (TV/Radio interviews, newspaper interviews, public service announcements, and editorial articles)	
Newsletters (electronic or print)	
Pamphlets, brochures, or fact sheets	
Academic course development	
Distance learning modules	
Doctoral dissertations/Master's theses	
Other	

Part 3

Instructions: For each product, publication and submission listed in Part 1, complete all elements marked with an "*."

Data collection form for: primary author in peer reviewed publications in scholarly journals published

*Title: _____

*Author(s): _____

*Publication: _____

*Volume: _____ *Number: _____ Supplement: _____ *Year: _____ *Page(s):_____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL): _____

*Dissemination Vehicles: TV/ Radio Interview___ Newspaper/ Print Interview___ Press Release___

Social Networking Sites/ Social Media___ Listservs___ Conference Presentation___

Key Words (No more than 5): _____

Notes: _____

Data collection form for: contributing author in peer reviewed publications in scholarly journals published

*Title: _____

*Author(s): _____

*Publication: _____

*Volume: _____ *Number: _____ Supplement: _____ *Year: _____ *Page(s):_____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL): _____

*Dissemination Vehicles: TV/ Radio Interview___ Newspaper/ Print Interview___ Press Release___

Social Networking Sites/ Social Media___ Listservs___ Conference Presentation___

Key Words (No more than 5): _____

Notes: _____

Data collection form: Peer reviewed publications in scholarly journals submitted, not yet published

*Title: _____

*Author(s): _____

*Publication: _____

*Year Submitted: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (No more than 5): _____

Notes: _____

Data collection form: Books

*Title: _____

*Author(s): _____

*Publisher: _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (No more than 5): _____

Notes: _____

Data collection form for: Book chapters

Note: If multiple chapters are developed for the same book, list them separately.

*Chapter Title: _____

*Chapter Author(s): _____

*Book Title: _____

*Book Author(s): _____

*Publisher: _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Reports and monographs

*Title: _____

*Author(s)/Organization(s): _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Conference presentations and posters presented

(This section is not required for MCHB Training grantees.)

*Title: _____

*Author(s)/Organization(s): _____

*Meeting/Conference Name: _____

*Year Presented: _____

*Type: ☐ Presentation ☐ Poster

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Web based products

*Product: _____

*Year: _____

*Type: ☐ Blogs ☐ Podcasts ☐ Web-based video clips

☐ Wikis ☐ RSS feeds ☐ News aggregators

☐ Social networking sites ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Electronic Products

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ CD-ROMs ☐ DVDs ☐ Audio tapes

☐ Videotapes ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Press Communications

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ TV interview ☐ Radio interview ☐ Newspaper interview ☐ Public service announcement ☐ Editorial article ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Newsletters

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ Electronic ☐ Print ☐ Both

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

*Frequency of distribution: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other (Specify)

Number of subscribers: _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Pamphlets, brochures or fact sheets

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ Pamphlet ☐ Brochure ☐ Fact Sheet

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Academic course development

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Distance learning modules

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Media Type:

- ☐ Blogs
- ☐ Podcasts
- ☐ Web-based video clips
- ☐ Wikis
- ☐ RSS feeds
- ☐ News aggregators
- ☐ Social networking sites
- ☐ CD-ROMs
- ☐ DVDs
- ☐ Audio tapes
- ☐ Videotapes
- ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Doctoral dissertations/Master's theses

*Title: _____

*Author: _____

*Year Completed: _____

*Type: ☐ Doctoral dissertation ☐ Master's thesis

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Other

(Note, up to 3 may be entered)

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Describe product, publication or submission: _____

_____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____